Mennonite Voluntary Service Health Plan

Summary Plan Description

Preferred Provider Organization

Cigna

Revised Aug. 1, 2020

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Schedule of Benefits

This page lists the schedule of benefits chosen by Mennonite Mission Network for its group health plan for Mennonite Voluntary Service participants (volunteers). It is only a summary of plan benefits. See *Part IX* for specific information and complete details about the benefits covered under this plan.

Medical benefits under this plan are provided through Cigna, a national preferred provider organization (PPO). It is your responsibility to make sure that a health care provider is part of the Cigna PPO before medical treatment is received. The health care provider you select can assist with this information. Otherwise, you may obtain this information by calling Everence at (800) 348-7468 or accessing the Cigna PPO directory online at www.cigna.com.

Plan Requirements	In-Network	Out-of-Network
Plan-year deductible	None.	$1,400 for single (self-only) coverage; $2,800 for family coverage.
Plan-year coinsurance	You pay $0; plan pays 100%.	You pay 40% of next $7,000 for all covered persons, combined.
Annual out-of-pocket maximum for deductible and coinsurance	Not applicable.	$4,200 for single (self-only) coverage; $5,600 for family coverage.
Precertification – inpatient admissions, transplants, and spinal procedures that puncture the skin	*Providers* are responsible to precertify services prior to an applicable spinal procedure, transplants, and all inpatient admissions.	*You* are responsible to make sure the provider precertifies services prior to an applicable spinal procedure, transplants, and all inpatient admissions.
Precertification – specialty pharmaceuticals	Caremark specialty pharmacies are not part of the PPO. *You* are responsible to precertify all specialty pharmaceuticals before treatment initially begins and the drugs are purchased. There are no plan benefits if you do not precertify specialty pharmaceuticals before purchase or if you do not purchase specialty pharmaceuticals from a Caremark specialty pharmacy, as directed by CVS Caremark.	
Filing claims	PPO provider files claims.	You are responsible to file claims.

Medical Benefits	In-Network	Out-of-Network[1]
Inpatient Facility Services		
• Hospital services[2] • Skilled nursing facility care[2], up to 100 days per plan year	Plan pays 100%.	You pay out-of-network deductible and coinsurance.
Outpatient Services		
• Physician/specialist services • Physician/specialist telehealth visits (virtual, video, and billable telephone consultations) • Urgent care facility services • Allergy testing and shots • Chemotherapy, radiation therapy, and kidney dialysis • Home health care • Health education programs • Medical supplies and equipment • Cardiac rehabilitation programs • Durable medical equipment and prosthetics • Outpatient surgery in hospital, outpatient surgical center, or physician office[2] • X-ray, lab, and diagnostic services • Physical medicine, up to 20 visits per year • Speech therapy, up to 20 visits per year • Occupational therapy, up to 20 visits per year • Spinal manipulations, up to 20 visits per year	Plan pays 100%.	You pay out-of-network deductible and coinsurance.
Dental and Vision Services		
• Annual routine eye exam • Glasses/contact lenses • Annual routine dental exam • Required dental services	Plan pays 100%. Not covered during first year of service. Annual maximum of $300 per adult and $500 per family (adults only) for all dental and vision services, combined. No maximum under age 19.	

Medical Benefits	In-Network	Out-of-Network[1]
Emergency Services		
• Ambulance • Hospital emergency room care	Plan pays 100%.	
Adult Preventive Care Services		
• Routine physical exams • Well-woman visits to obtain preventive services • Routine gynecological exam and pap test • Routine diagnostic screenings, including complete blood count (CBC) and urinalysis • Mammograms – annual routine screening • Routine prostate specific antigen test and/or digital rectal exam	Plan pays 100%. Not covered during first year of service.	No plan benefit.
• As prescribed, FDA-approved contraceptive methods (including sterilization) for all women with reproductive capacity • As prescribed, risk-reducing breast cancer medications for women without a cancer diagnosis who are at increased risk for breast cancer and low risk for adverse medication effects • Routine adult immunizations	Plan pays 100%.	No plan benefit.
Pediatric Preventive Care Services		
• Routine physical exams • Routine diagnostic screenings	Plan pays 100%. Not covered during first year of service.	No plan benefit.
• Routine pediatric immunizations	Plan pays 100%.	No plan benefit.
Hospice Services		
• Inpatient services[2] • Outpatient services	Plan pays 100%.	You pay out-of-network deductible and coinsurance.
Mental Health Services		
• Inpatient treatment[2] • Outpatient treatment (includes telehealth behavioral health visits)	Plan pays 100%.	You pay out-of-network deductible and coinsurance.
Substance Abuse Services		
• Inpatient detoxification[2] • Inpatient rehabilitation[2] • Outpatient treatment (includes telehealth treatment visits)	Plan pays 100%.	You pay out-of-network deductible and coinsurance.

[1]Plan payments for services received from an out-of-network provider are based on the reasonable and customary (R&C) charges for the type of care, service, or treatment received. If the provider's charges are more than the reasonable and customary (R&C) charges, you will be responsible for paying the difference. Any of these extra amounts you have to pay will not count toward your plan-year out-of-network deductible and coinsurance requirements.

[2]Precertification required, as outlined in *Part VIII*.

Outpatient Prescription Drug Benefit	
• Tier 1 Generic drugs[3]	Plan pays 100%.
• Tier 2 Preferred brand-name drugs on the Preferred Drug List[3]	Plan pays 100%.
• Tier 3 All other brand-name drugs[3]	Plan pays 100%.
• Tier 4 Specialty Pharmaceuticals[2]	Plan pays 100%.

[3]Prior authorization required for compound drugs costing $300 or more and any drug costing $5,000 or more.

Part I, Introduction

This summary plan description describes the medical benefits provided by the Mennonite Voluntary Service Health Plan for eligible Mennonite Voluntary Service (MVS) participants and their qualified dependents. The summary plan description will tell you how you can be covered by the plan, how to file a claim, and other important information about how the plan works. Please read it carefully.

The Mennonite Voluntary Service Health Plan believes the plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

If you have questions about the plan or about points in the plan that aren't covered in the summary plan description, please talk to the plan representative. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status may also be directed to the plan representative. The name of the plan representative is listed in *Part XVII*.

Claims for the plan will be handled by a claims administrator who is trained in the benefits offered by the plan. The claims administrator's name, address, and phone number are:

Everence Insurance Company (Everence)
1110 N. Main St.
P.O. Box 483
Goshen, IN 46527-0483
(574) 533-9511 or (800) 348-7468

Part II, Definitions

The following words and terms are used in this summary plan description. When used, this is what they mean:

Ambulatory surgical facility — A licensed public or private establishment that:
1. Has an organized medical staff of physicians;
2. Has permanent facilities to provide chiefly elective surgical care, continuous physician services, and nursing services;
3. Is properly licensed by all applicable regulatory agencies;
4. Maintains medical records for each patient;
5. Does not have facilities for patients to stay overnight; and
6. Does not exist for the purpose of terminating pregnancies.

Assignment of benefits — Your authorization to Everence, the claims administrator, to pay plan benefits directly to the medical care provider (physician or hospital, for example).

Calendar year — The 12-month period from Jan. 1 through Dec. 31 of any year.

Claims administrator — The person or firm appointed by the plan who is given authority by the plan to perform enrollment, claims, and other administrative services in connection with the operation of the plan, according to the terms of the plan. The claims administrator for this plan is Everence Insurance Company (Everence).

Coinsurance — The specific percentage of covered charges for certain eligible expenses you and the plan share each plan year after the deductible requirement is met, when services are received from an out-of-network provider.

Covered charge — An expense for care, services, or treatment that is incurred by a covered person after his or her effective date of coverage and is eligible to be paid, either in whole or in part, by the plan in accordance with its terms.

Covered person — A volunteer or dependent who meets the eligibility criteria outlined in *Part III* and is enrolled in and receiving benefits under this plan.

Creditable coverage — Includes coverage under any of the following:
1. A group health plan;

2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act;
4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;
5. Chapter 55 of Title 10, United States Code;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5, United States Code;
9. A public health plan established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); and
11. Title XXI of the Social Security Act, State Children's Health Insurance Program (S-CHIP).

Creditable coverage does not include:
1. Coverage only for accident or disability income insurance, or any combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics; and
8. Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

Custodial care — Any type of service that is designed to assist you or your covered dependent, whether disabled or not, in the activities of daily living. Such services include assistance in walking or getting in and out of bed, bathing, dressing, feeding, preparation of special diets, and supervision over medication that can normally be self-administered.

Deductible — The specific dollar amount you or your covered dependent must pay for eligible expenses each plan year before benefits are payable, in whole or in part, under this plan. The deductible requirement applies only when services are received from an out-of-network provider.

Emergency — A medical condition manifesting itself (including injuries) by acute signs or symptoms that could reasonably result in placing a covered person's life or limb in danger if immediate medical attention is not provided.

Experimental medical treatment — Those services or supplies not recognized or proven to be effective treatment of a diagnosed disease or injury in accordance with generally accepted standards of medical practice. The service or supply must not be considered experimental, investigational, or for research purposes by the American Medical Association, the National Institutes of Health, the U.S. Dept. of Health and Human Services, or the U.S. Food and Drug Administration.

Home health care agency — An agency that specializes in giving nursing and other therapeutic services in the home. The agency provides services prescribed by a covered person's attending physician in a formal treatment plan (home health care plan) for the individual's care. The agency must be approved as such by the state in which it is located, have a full-time administrator, and maintain a complete record on each individual.

Home health care plan — A program for the care and treatment of a covered person that is established and approved by the covered person's attending physician in lieu of inpatient confinement.

Hospice care agency — An agency that provides counseling, medical services, and possibly room and board to terminally ill individuals. A hospice care agency must:
1. Be licensed as such by the state in which it is located;
2. Provide services 24 hours a day, seven days a week;
3. Exist mainly to provide hospice services;
4. Be directly supervised by a physician;
5. Have a full-time administrator, a licensed social service coordinator, and a registered nurse coordinator; and
6. Maintain written records of its services provided to the patient.

Hospice care program — A coordinated, interdisciplinary program for meeting the physical, psychological, spiritual, and social needs of terminally ill people and their families. The program provides palliative health and other supportive services through home, outpatient, or inpatient care during the illness and bereavement.

Hospital — A legally operating institution that:
1. Provides — for a fee — diagnostic, medical, and surgical care and treatment of ill or injured persons;
2. Has a staff of one or more physicians on call at all times;
3. Provides 24-hour nursing services under the full-time supervision of a registered nurse (R.N.);
4. Has inpatient facilities; and
5. Is accredited as a hospital by the Joint Commission, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities.

The term *hospital* **does not** include a clinic, rest home, extended care facility, convalescent nursing home, home for the aged, or a place that provides chiefly custodial care.

Illness — A physical or mental disorder or infirmity that interferes with normal bodily functions. It includes pregnancy and pregnancy-related conditions. It does not include any condition a covered person develops as the result of work for wage or profit and which is covered by Workers' Compensation.

Immediate family — A covered person's spouse, child, parent, sibling, or in-law.

Incurred — A charge is incurred on the date the care, service, treatment, or supply is performed or provided.

Infertility — The presence of a demonstrated condition recognized by a licensed physician or surgeon that prevents conception or carrying a pregnancy to term.

Injury — Bodily damage caused by accidental, unexpected, external means while this plan is in effect. It does not include injuries a covered person receives in connection with his or her job or any other occupation for which the covered person is paid.

Lifetime — The entire time an individual is enrolled in and covered under this plan. For purposes of this plan, lifetime does not have any reference to the natural lifespan of a covered person.

Medically necessary — The need for medical intervention to treat an injury or illness. In order to be medically necessary, the care, service, or treatment a covered person receives must be recommended or prescribed by the attending physician as essential to treat his or her condition. In addition, it must be in accordance with accepted medical standards and approved by regulators such as the U.S. Food and Drug Administration. Everence, as claims administrator, determines whether or not a particular type of care, service, or treatment is medically necessary taking into consideration the nature of the covered person's condition.

Mental disorder — A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional illness of any kind that is generally believed in the medical community to be treatable.

Mental health professionals — Includes licensed social workers, licensed professional counselors (LPC), licensed psychiatrists, and licensed psychologists. It also includes other psychotherapists, but they must be under the direct supervision of a licensed psychiatrist or licensed psychologist.

Occupational therapy — Treatment to prevent disability or to restore a disabled person to health, social, or economic independence. Occupational therapy includes programs to restore or develop the person's self-care, work, or leisure time skills. Occupational therapy that is a recreational program is not covered under this plan.

Other coverage — The amount of any benefits paid or value received from other insurance or benefit plans for the same loss.

Partial hospitalization — A distinct and organized intensive ambulatory treatment service. It is less than 24-hour daily care specifically designed for the diagnosis and active treatment of an individual's mental illness or substance abuse (as defined in this document) when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization. It may include day, night, evening, or weekend care. This intensive ambulatory psychiatric treatment includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational treatment modalities usually found in a comprehensive hospital program. Partial hospitalization may include group and family therapies, individual therapy, pharmacotherapy, psychodrama, and occupational/recreational therapies in a distinct, structured therapeutic environment. Partial hospitalization operates in a hospital, is medically supervised, and is at least three hours in duration per patient visit. Admission to or release from partial hospitalization must be approved by a qualified physician.

Physical medicine — When prescribed by a physician, the medically necessary and appropriate outpatient treatment of illness or injury by physical agents such as heat, cold, light, electricity, or the use of mechanical devices. The intention of treatment is restoration, not maintenance or enhancement of bodily function. Physical medicine includes, but is not limited to:

1. Physical therapy,
2. Cognitive therapies,
3. Biofeedback, and
4. Sports medicine.

Physical medicine does not include:

1. Membership fees for exercise facilities and health spas;
2. Payment for exercise-type equipment;
3. Spinal manipulations; or
4. Treatment programs not administered by a physician or licensed therapist.

Physician (doctor) — For the purposes of the plan, a physician is a legally licensed practitioner of the healing arts who is providing services within the scope of his or her license. This definition does not include you, a member of your immediate family, or co-workers.

Plan — The Mennonite Voluntary Service Health Plan for eligible Mennonite Voluntary Service (MVS) participants and their qualified dependents, as set forth in this summary plan description and as amended from time to time.

Plan administrator — The person or entity that maintains the records of the plan, administers the plan, has discretionary authority to interpret the provisions of the plan, and makes all decisions necessary or proper to carry out the terms of the plan. The plan administrator may delegate its responsibilities to other persons or entities. The plan administrator for this plan is Mennonite Mission Network.

Plan participant — Any individual enrolled in and covered under this plan.

Plan year — The plan's fiscal year. It is the 12-month period beginning each Aug. 1 and ending the following July 31.

Pre-transplant stabilization — An inpatient stay to medically stabilize a covered person for purposes of, or preparation for, a later transplant, whether or not the transplant occurs.

Prescription drug — A drug or compound that can only be purchased with a physician's prescription from a legally licensed pharmacist.

Qualified Medical Child Support Order (QMCSO) — A medical child support order that:

1. Creates or recognizes the existence of a child's right to, or assigns to a child, the right to receive benefits for which a participant is eligible under the plan;
2. States the name and last known mailing address of the participant and the name and mailing address of each child (alternate recipient) covered by the order;
3. Contains a reasonable description of the type of coverage to be provided;
4. Specifies the period to which such order applies;
5. Identifies the plan to which such order applies; and
6. Does not require the plan to provide any type or form of benefit or any option not otherwise provided under the plan, except to the extent necessary to meet the requirements of a state law as described in Section 1908 of the Social Security Act, as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993.

Reasonable and customary (R&C) charge — The fee most frequently charged by other hospitals, physicians, and service providers in the geographical area where the care, service, or treatment is given for the same type of care, service, or treatment, taking into consideration the nature and severity of the covered person's condition. The reasonable and customary (R&C) charge is determined by the claims administrator (Everence).

Skilled care — Skilled nursing, teaching, and rehabilitation services when they:

1. Are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
2. Are ordered by a physician;
3. Are not delivered for the purpose of assisting with activities of daily living, including, but not limited to, dressing, feeding, bathing, or transferring from a bed to a chair;
4. Require clinical training in order to be delivered safely and effectively; and

5. Are not custodial care, as defined in this *Part II*.

Skilled nursing facility — A legally licensed and operated institution (or special unit of a hospital) that:
1. Is approved for payment of Medicare benefits or is qualified to receive this approval;
2. Provides (in addition to room and board) skilled nursing care and rehabilitation services under the supervision of a physician;
3. Has 24-hour nursing service provided or supervised by a registered graduate nurse;
4. Maintains a daily medical record of each patient; and
5. Has an effective utilization review plan.

A skilled nursing facility is not a facility (or part of a facility) used mainly for treatment of mental disorders, substance abuse, custodial care, or educational care.

Sound natural teeth — Teeth that are whole or properly restored and without impairment, periodontal, or other conditions and which are not in need of treatment for any reason other than an accidental injury.

Specialty pharmaceuticals — Includes self- or physician-administered oral, injectable, and infused medications that are biopharmaceuticals (bioengineered proteins), blood-derived products, and complex molecules. In general, covered specialty pharmaceuticals include, but are not limited to blood modifiers and drugs prescribed for the treatment of respiratory syncytial virus (RSV), growth hormone deficiency, Crohn's disease, hepatitis C, hemophilia, Gaucher's disease, cystic fibrosis, multiple sclerosis, rheumatoid arthritis, asthma, enzyme replacement, immune deficiencies, pulmonary arterial hypertension, and other chronic low prevalence diseases.

Speech therapy — Treatment by a qualified speech therapist to restore speech loss or to correct an impairment caused by an injury or illness or due to a congenital defect for which corrective surgery has been performed.

The plan does not cover speech therapy to correct voice modulation; lisp; or an impairment due to a learning disability or a mental, psychoneurotic, or personality disorder.

Spouse — A member of the opposite sex to whom the volunteer is legally married. An Affidavit of Marriage may be required if there is a question to the legality of the marriage.

Subacute care — Comprehensive, goal-oriented, inpatient and outpatient care of an acute illness, injury, or exacerbation of a disease process provided immediately after or instead of acute hospitalization. Subacute care is generally more intensive than that provided in a traditional nursing facility and less intensive than that offered in an acute care hospital.

Substance abuse — Any use of alcohol or drugs that produces a pattern of pathological use causing impairment in social or occupational functioning or produces physiological dependency evidenced by physical tolerance or withdrawal.

Terminally ill — Having a life expectancy of six months or less as certified in writing by the attending physician.

Transplant — One complete series of a transplant including the pre-transplant evaluation, harvesting, stabilization, and the transplant itself. It includes a subsequent transplant if the first was rejected.

Unbundling (unbundled) — The process of:
1. Charging for separate components of a procedure when they should be part of a single global fee for the procedure; or
2. Charging for a service separate from the global fee for a procedure when the charge for the service is already included in the global fee.

Unbundling often results in multiple billing, creating a total fee that is higher than the global fee for the procedure as a whole.

Urgent care — Any service received for the treatment of a non-life-threatening condition that requires immediate medical attention to minimize severity and prevent complications.

Urgent care facility — A freestanding facility that:
1. Is engaged primarily in providing minor emergency and episodic medical care to a covered person;
2. Is either accredited by the Joint Commission or licensed by the state in which it is located;
3. Includes x-ray and laboratory equipment and a life support system as part of the facilities; and
4. Is not located on or in conjunction with and is not in any way a part of a regular hospital.

Volunteer — Any long-term (minimum of one year) Mennonite Voluntary Service participant of Mennonite Mission Network.

You, your — The Mennonite Voluntary Service (MVS) participant who is enrolled in this plan and to whom this summary plan description is issued.

Part III, Participation — Who Can Be Covered

A. Eligible Individuals

You are eligible to be covered under this plan if you are a long-term participant (minimum of one year) in the Mennonite Voluntary Service program of Mennonite Mission Network.

You remain eligible to be covered under this plan for a maximum of eight weeks if you are unable to continue your MVS service assignment due to a medical condition. You also remain eligible to be covered under this plan for a maximum of eight weeks if you are on a non-medical leave of absence as allowed by the Leave policy outlined in the MVS Policy Handbook and approved by Mennonite Mission Network. If you are not able to resume your MVS service assignment after eight weeks due to your medical condition or the circumstances of the leave of absence, coverage under this plan will terminate, unless you purchase extended coverage (see *Part XIII*).

B. Dependents

If you enroll in the plan, your dependents may also enroll in the plan. A *dependent* is:

1. Your husband or wife (spouse), provided you are not divorced or legally separated. **However, if your spouse has access to group health coverage sponsored by or provided by his or her employer (regardless of whether your spouse enrolls in the coverage), your spouse is not eligible to enroll in this plan.**
2. Your children under the age of 26. Your child's marital status, financial dependency, employment, residency, or student status will not be considered in determining eligibility for plan coverage to age 26.
3. Your unmarried children ages 26 and older who are disabled and principally dependent on you for support and maintenance (as outlined in *Part III, Section C*).

A dependent also includes a child for whom you are required to provide medical coverage pursuant to a Qualified Medical Child Support Order (see definition in *Part II*).

For the purposes of plan coverage, the word *children* means all biological children, legally adopted children, or stepchildren who meet the age requirements. The word *children* also includes a minor for whom you have accepted legal guardianship.

To be eligible for dependent coverage, proof that dependents meet the above definition may be required.

You must notify the plan representative if your covered spouse gains access to employer-provided group health plan coverage.

C. Dependents Who Are Disabled

If your dependent child is physically or mentally disabled and because of the disability is not able to earn a living, your child can continue to be covered as your dependent after he or she reaches age 26. In order to be eligible for plan coverage beyond age 26, your child must have become disabled before his or her 26th birthday and must continue to be entirely dependent on you for support and maintenance.

You will have to give the claims administrator (Everence) a written notice from your physician that documents your child's disability within 30 days after your child's 26th birthday. Everence may ask you to provide written proof from your physician once a year certifying your child's continuing disability. You will have to pay the full cost of any required proof or certification.

Plan coverage for a disabled dependent will continue as long as you are covered by the plan or until the earlier of the following events:

1. Your child is no longer disabled;
2. Your child is no longer entirely dependent on you for support and maintenance;
3. You do not provide proof of your child's continuing disability when Everence asks for it; or
4. Your child gets married.

D. General Provisions

If more than one family member is a participant in the MVS program, plan benefits will be identical to those you would receive if only one family member was participating in the MVS program. If both you and your spouse are MVS participants, your children will be enrolled either as your dependents or your spouse's dependents.

It is very important for Mennonite Mission Network to have correct, up-to-date information about you and your dependents. **Be sure to let the plan representative know when your address or any other personal information changes that may affect your coverage, such as your marital status, the number of your dependents, their names and birth dates, etc.** This information is needed to be sure the plan is operating as it should. Changes must be reported to the plan representative within 30 days following the change.

Part IV, Enrollment — When Coverage Starts

A. When Coverage Begins

Coverage for benefits begins immediately upon meeting the eligibility and enrollment requirements outlined in *Part III* and *Part IV*.

B. Initial Enrollment for MVS Participants

In order to be covered by the plan, you must enroll yourself and each of your qualified dependents (if you want dependent coverage) by completing and returning the *Enrollment for Mennonite Voluntary Service Health Plan* form to the plan representative within the 30-day enrollment period that immediately follows the first day of your MVS service assignment. This form may be obtained from the plan representative. Your coverage will begin on the first day of your MVS service assignment if you enroll in the plan within the 30-day enrollment period. Your dependents' coverage will begin at the same time as your coverage as long as you also enroll your dependents within the 30-day enrollment period.

C. Enrolling New Dependents

New dependents can be enrolled in the plan any time within the 30-day enrollment period that immediately follows the day a dependent first becomes eligible for coverage through birth, placement for adoption, adoption, or marriage. However, your dependents are not eligible for coverage under this plan unless you are enrolled in the plan.

Coverage for new dependents added through marriage begins on the day of marriage if they are enrolled in the plan within the 30-day enrollment period.

Coverage for a newborn child begins on the day of birth if the newborn is enrolled in the plan within the 30-day enrollment period that immediately follows the day of birth.

Coverage for a newly-adopted child begins on the earlier of the day of adoption, placement in your home, or when you assume financial responsibility, if the newly-adopted child is enrolled in the plan within the 30-day enrollment period that immediately follows the day of adoption or placement for adoption.

You can enroll new dependents by completing and returning the *Enrollment for Mennonite Voluntary Service Health Plan* form to the plan representative. If you are already enrolled in the plan when you add your first dependent, you will get a new membership card showing your dependent coverage.

D. Special Enrollment Periods

Note: The Outbreak Period is disregarded when determining the deadline for special enrollment. The Outbreak Period is the period beginning March 1, 2020 and ending 60 days after the announced end of the COVID-19 national emergency.

Waiver of Coverage

If you and/or your dependents are eligible for coverage under this plan but waive coverage due to enrollment in other creditable coverage (see definition in *Part II*), you and/or your dependents may enroll in this plan later without being considered a late enrollee if employer contributions toward the other creditable coverage terminate or if eligibility for the other creditable coverage ends as a result of:

1. Termination of employment;
2. Involuntary termination of the other health plan;

3. Reduction in the number of hours of employment;
4. Legal separation, divorce, or death of a spouse;
5. Discontinuance of dependent coverage by the other health plan; or
6. Marriage.

You and/or your dependents must enroll in this plan within the 30-day special enrollment period that immediately follows the day the other creditable coverage ends (or employer contributions terminate).

The effective date of coverage for an eligible individual who loses other creditable coverage will be the day after the other creditable coverage ends (or employer contributions terminate) as long as he or she enrolls in the plan within the 30-day special enrollment period.

You must inform the plan representative and complete the waiver section of the *Enrollment for Mennonite Voluntary Service Health Plan* form if you are waiving coverage for yourself or any dependent.

Special Enrollment Period When New Dependents Become Eligible for Coverage

An eligible volunteer who has not enrolled in the plan can also enroll at the same time a new dependent becomes eligible for coverage through marriage, birth, or adoption. Both the volunteer and the new dependent must enroll within the 30-day special enrollment period that immediately follows the day the new dependent becomes eligible to enroll in the plan.

Similarly, an eligible spouse who has not enrolled in the plan can enroll at the same time as a newborn or newly-adopted child. Both the spouse and the new dependent must enroll within the 30-day special enrollment period that immediately follows the day the new dependent becomes eligible to enroll in the plan.

The effective date of coverage will be the date of marriage, birth, placement for adoption, adoption, or when you assume financial responsibility for an adoptive child, whichever is relevant.

Special Enrollment Periods Required by the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009

If you and/or your dependents are eligible for coverage under this plan but waive coverage because you and/or your dependents are enrolled in Medicaid or a state Children's Health Insurance Program (CHIP), you and/or your dependents may enroll in this plan later without being considered a late enrollee if Medicaid or CHIP coverage ends because of loss of eligibility.

In addition, if you and/or your dependents are eligible for coverage under this plan but choose not to enroll, you and/or your dependents may enroll in this plan later without being considered a late enrollee if you and/or your dependents become eligible for a state group health plan premium assistance subsidy under Medicaid or CHIP which provides help in paying for coverage under this plan.

You and/or your dependents must enroll in this plan within the 60-day special enrollment period that immediately follows the date coverage under Medicaid or CHIP terminates or the date it is determined that you and/or your dependents are eligible for a state premium assistance subsidy, whichever applies.

The effective date of coverage will be the day after Medicaid or CHIP coverage terminates or the date you and/or your dependents become eligible for the state premium assistance subsidy, whichever applies.

E. Late Enrollment

Any eligible individual not enrolling in the plan within his or her respective enrollment or special enrollment period becomes a late enrollee. A late enrollee is only eligible to enroll in the plan during the annual open enrollment period that begins June 1 and ends July 15. To enroll for coverage, the *Enrollment for Mennonite Voluntary Service Health Plan* form must be completed and returned to the plan representative before the end of the open enrollment period. The effective date of coverage for a late enrollee will be the following Aug. 1.

Part V, Basis of Coverage — What Coverage Costs

The plan is currently funded by contributions made by Mennonite Mission Network. Mennonite Mission Network will contribute all of the monthly cost of coverage for you and your covered dependents.

Plan participants who extend coverage after their MVS service assignment ends (see *Part XIII*) may contact the plan representative to determine the premium for extended coverage.

In addition to these contributions, all plan participants are responsible for paying:
1. Deductibles, when services are received from an out-of-network provider;
2. Coinsurance, when services are received from an out-of-network provider;
3. Charges that exceed the reasonable and customary (R&C) charge, when receiving services from an out-of-network provider;
4. Unbundled charges not paid by the plan; and
5. Charges for care, services, treatment, and supplies not covered by the plan.

Part VI, How Your Health Coverage Works

You need to know:
1. If you or your dependents receive care from a provider that is not part of the Cigna PPO network, plan payments for provider services are based on the reasonable and customary (R&C) charges for the type of care, service, or treatment received. This charge is determined by the claims administrator, and is the smaller of:
   a. The normal charge the provider would make for a service or supply if you had no health coverage; or
   b. The prevailing charge made by other physicians and hospitals in the area for the same type of service or supply, taking into consideration the seriousness of the covered person's illness or injury.

   If the provider charges are more than the reasonable and customary (R&C) charges, you will be responsible for payment of the difference. Any of these extra amounts you have to pay will not count toward your plan-year out-of-network deductible and coinsurance requirements.

2. If the provider charges submitted have been unbundled (see definition in *Part II*), the unbundled charges will be processed according to the correct coding. The plan will not cover any amounts that exceed the correct coding charge.

   Any of the extra amounts you have to pay for unbundled charges will not count toward meeting your plan-year out-of-network deductible and coinsurance requirements.

3. The plan does not pay charges for treatment of an illness or injury you or your covered dependent may receive or develop as the result of any work for wage or profit. This provision applies to any illness or injury covered by Workers' Compensation, occupational disease, or similar law. However, if specific coverage for such an illness or injury is not in effect **and** is not required by law, this plan will cover eligible charges for treatment of the illness or injury.

A. Plan-year Deductible

In-Network

Plan-year deductible for single (self-only) coverage.. $0
Plan-year deductible for family coverage.. $0

There is no deductible requirement when you or your covered dependents receive services from a provider that is part of the Cigna PPO network.

Out-of-Network

Plan-year deductible for single (self-only) coverage.. $1,400
Plan-year deductible for family coverage.. $2,800

If you or your covered dependents receive services from a provider that is not part of the Cigna PPO network, you are responsible to pay the out-of-network deductible listed above and in the Out-of-Network column in the *Schedule of Benefits* for covered services each plan year before the plan pays for all or a portion of eligible expenses for the remainder of the plan year. You are responsible for paying all of the charges to which the deductible applies until you have paid the out-of-network deductible requirement. Only expenses eligible under this plan can be applied toward meeting the out-of-network deductible requirement.

If you are the only person covered under this plan, you have met your out-of-network deductible when you have paid eligible expenses equal to the plan-year deductible for single (self-only) coverage listed above. If your family is covered

under this plan, you have met your out-of-network deductible when the combined eligible expenses you have paid for all covered family members is equal to the deductible for family coverage listed above. **If only one family member has medical expenses, that person must meet the entire deductible for family coverage before benefits are payable by the plan.**

The accumulation period for the out-of-network deductible is a plan year, beginning Aug. 1 and ending the following July 31.

B. Plan-year Coinsurance

In-Network

There is no coinsurance requirement when you or your covered dependents receive services from a provider that is part of the Cigna PPO network.

Out-of-Network

If you or your covered dependents receive services from a provider that is not part of the Cigna PPO network, you are responsible to meet an out-of-network coinsurance requirement. After you have met your out-of-network deductible requirement, the plan will pay 60 percent of the next $7,000 of covered charges for all covered persons, combined. You are responsible for paying the other 40 percent.

Only eligible expenses under this plan can be applied toward meeting the out-of-network coinsurance requirement. Expenses used to meet the out-of-network deductible are not applied toward meeting the out-of-network coinsurance requirement.

At the beginning of each plan year, after you have met the out-of-network deductible requirement, you must meet a new out-of-network coinsurance requirement.

C. Annual Out-of-Pocket Maximum for Out-of-Network Services

The annual out-of-pocket maximum is the specific dollar amount of deductible and coinsurance you must pay for eligible health care expenses received from providers who are not part of the Cigna PPO network each plan year before the plan begins to pay 100 percent of additional eligible expenses for out-of-network services (except when maximum benefits have been received). The out-of-pocket maximum for out-of-network services is listed in the *Schedule of Benefits*. The out-of-pocket maximum does not include expenses not covered by the plan and amounts in excess of the provider's reasonable and customary (R&C) charge.

D. Maximum Benefits

The benefits provided by this plan are not subject to an overall annual or lifetime dollar maximum for any covered person.

Some benefits have plan-year maximum limits on the number of days or number of services covered by this plan. These maximums are listed in the *Schedule of Benefits* and described in *Part IX.*

Part VII, Preferred Provider Organization

A. Requirements for Receiving Care

Your health coverage under this plan is arranged through Cigna, a preferred provider organization (PPO) network of physicians, hospitals, and other medical care providers who have agreed to help reduce your costs for health care.

Using a preferred provider when receiving medical treatment, services, or supplies will give you and your dependents maximum benefits under the plan.

If you or your dependents do not use a preferred provider, you are responsible to make sure your medical care provider follows the precertification procedures outlined in *Part VIII.*

B. Definitions

Medical care provider — A specific provider of medical, mental health, or substance abuse care, services and supplies that is properly licensed, credentialed, and/or accredited by all applicable regulatory agencies. It includes, but is not limited to, hospitals, physicians, ambulatory surgical centers, and medical supply centers.

Preferred provider — A specific medical, mental health, or substance abuse care provider furnishing medical services and supplies as a part of the PPO agreement. The providers are listed in the directory of providers which may be accessed through the Cigna website, www.cigna.com, in the “Find a Doctor, Dentist, or Facility” section. You may also call Everence at (800) 348-7468 to locate the preferred provider nearest to you or verify that your current provider is in the Cigna PPO network.

Preferred Provider Organization (PPO) — A formal association of medical, mental health, and substance abuse care providers that have entered into a preferred provider agreement in regard to this plan of coverage.

C. Benefits When Using a Preferred Provider

You and your dependents have the responsibility, when selecting a medical, mental health, or substance abuse care provider, to select a provider within the Cigna PPO network in order to receive the maximum benefits payable under this plan. When a preferred provider is used, there is no deductible or coinsurance requirement.

When you or your dependents use a preferred provider, the provider will precertify the covered person’s care and in most cases, file the claim for you.

D. Reduced Benefits When a Preferred Provider is Not Used

If you or your dependents receive eligible services from a provider that is not part of the Cigna PPO network — unless it is an exception listed in *Part VII, Section E* — benefits will be reduced. You will be responsible to pay the out-of-network deductible and coinsurance requirement listed in the Out-of-Network column in the *Schedule of Benefits* and outlined in *Part VI, Section A* and *Section B*. You will also be responsible to pay all charges that exceed the reasonable and customary (R&C) charges for eligible services received.

If you or your covered dependents receive preventive care services from a provider that is not part of the Cigna PPO network, there are no plan benefits and you will be responsible to pay the charges.

If you or your dependents do not use a preferred provider, you are responsible to make sure the medical care provider follows the precertification requirements outlined in *Part VIII*.

Failure to precertify as well as not using a preferred provider when required will result in a reduction of benefits of $250 in addition to the deductible and coinsurance requirements outlined in this *Section D*.

If you or your dependents do not use a preferred provider for any reason, you or your medical care provider must also submit the claim directly to the address on the back of your membership card.

E. When a Preferred Provider is Not Required

Receiving care through a preferred provider is not required in these situations:

1. In the event of an *emergency* (see definition in *Part II*);
2. When medically approved treatment prescribed by the attending physician is not available through a preferred provider;
3. When a specific covered service or its therapeutic equivalent is not available through a preferred provider;
4. When receiving routine dental and vision services (see *Part IX, Section C* and *Section W*); and
5. When *urgent care* (see definition in *Part II*) is not available through a preferred provider.

In these situations, there is no deductible or coinsurance requirement.

In an emergency that results in hospitalization or requires follow-up medical treatment, your medical care provider must call the precertification number on your membership card to provide information about the need for continued medical care. This must be done within 48 hours after the emergency treatment, or as soon thereafter as reasonably possible.

If emergency treatment is being provided by a provider outside the Cigna PPO network, you or your dependents may be required — when medically appropriate — to transfer to a provider within the Cigna PPO network.

If you or your dependents do not transfer to a provider within the Cigna PPO network as requested when medically appropriate, you will be subject to the out-of-network deductible and coinsurance requirements, as outlined in *Part VI, Section A* and *Section B*. This reduction in benefits can be applied in addition to the reduction in benefits for failing to precertify.

F. Outpatient Prescription Drugs and Specialty Pharmaceuticals

Pharmacies are not part of the Cigna PPO network. See the *Outpatient Prescription Drug Rider* attached to this summary plan description for guidelines when purchasing outpatient prescription drugs.

Caremark specialty pharmacies are also not part of the Cigna PPO network. Specialty pharmaceuticals must be purchased from a Caremark specialty pharmacy, as directed by CVS Caremark to be covered by the plan. See *Part VIII, Section E*, for guidelines when purchasing specialty pharmaceuticals.

G. Directory of Providers

The most up-to-date directory of providers is available through the Cigna website, www.cigna.com, in the "Find a Doctor, Dentist, or Facility" section. The directory serves as a guide only, since preferred providers may be added to or deleted from this list without direct notice to you. It is your responsibility to make sure that a medical care provider is still a preferred provider before receiving medical treatment. The medical care provider that you select can assist with this information. Otherwise, you may call Everence at (800) 348-7468 to get this information.

H. Assignment of Claims Benefits

When you or your dependents use a preferred provider, the plan requires that claims benefits be assigned to that provider. The preferred provider will bill the plan directly for any services received. The plan will pay the provider directly.

I. Termination of the PPO Arrangement

In the event the arrangement with the PPO ends, the plan will pay benefits as listed in the In-Network column in the *Schedule of Benefits*.

Part VIII, Precertification and Claims Management

You are responsible to make sure the medical care provider follows the precertification requirements outlined in this *Part VIII* if:

1. **You or your dependents do not use a preferred provider as outlined in *Part VII*; or**
2. **You or your dependents require specialty pharmaceuticals**.

When you or your dependents use a preferred provider, in most cases, the medical care provider will precertify the patient's care. **However, certain Mayo Clinic providers who are preferred providers are not required to precertify spinal procedures that puncture the skin that are performed at Mayo Clinic. You are responsible to contact the claims administrator (Everence Insurance Company) at (800) 348-7468 to make sure these spinal procedures performed by Mayo Clinic providers at Mayo Clinic are covered by the plan. If the spinal procedure is not covered by the plan, you will be responsible to pay the entire cost of the procedure.**

If you or your dependents do not use a preferred provider, you are responsible to make sure that your provider notifies Cigna in advance by calling the Everence telephone number listed on your membership card if you or your dependents need:

1. Inpatient care;
2. An organ or tissue transplant; or
3. Any outpatient spinal procedure that punctures the skin.

This plan also requires that you notify CVS Caremark in advance if you or your dependents require specialty pharmaceuticals.

Through this process Cigna and CVS Caremark can help reduce costs without sacrificing the quality of care. All rules and guidelines for this are given below. Please read all the instructions carefully.

If the procedures in this part are not followed, benefits will be reduced as explained in *Section F* of this *Part VIII*.

A. Hospitalization and Other Inpatient Treatment

If you do not use a preferred provider, you are responsible to make sure the medical care provider notifies Cigna by calling the Everence telephone number listed on your membership card before any inpatient admission to a:

1. Hospital, including admission for mental or substance use disorders (note: partial hospitalization does not require precertification);
2. Nursing facility providing skilled nursing care;
3. Rehabilitative center; or
4. Facility providing subacute care (see definition in *Part II*).

Cigna will certify by telephone and in writing:

1. The medical necessity of the admission;
2. The appropriateness of the treatment for the illness or injury;
3. The length of the stay eligible for benefits; and
4. The extension of a certified stay eligible for benefits.

Instructions Before a Planned Admission

Cigna will also let the medical provider know:

1. If outpatient lab tests and x-rays should be done before a planned admission to any medical facility. The tests must be:
   a. Ordered by a physician;
   b. Consistent with the patient's diagnosis; and
   c. Performed within seven days prior to the admission.
2. If surgery is recommended as inpatient or outpatient; and
3. If a second surgical opinion is required.

If the Inpatient Stay is Longer Than Cigna Certified

This plan will not pay for an inpatient stay that extends beyond the number of days Cigna has certified — unless Cigna has also approved the extension.

B. Organ and Tissue Transplants

If you require an organ or tissue transplant and do not use a preferred provider, you are responsible to make sure the medical care provider notifies Cigna by calling the Everence telephone number listed on your membership card in advance before the donor search and selection process begins.

When an organ or tissue transplant procedure is approved, Cigna will recommend, in consultation with the covered person's physician, that the transplant be performed in a designated facility. A facility is designated when it appears on Cigna's list of centers designated for the specific transplant being performed. Designated facilities are those that have demonstrated proficiency in a specific transplant procedure. The credentials of each facility are reviewed annually.

C. Spinal Procedures that Puncture the Skin

If you do not use a preferred provider, you are responsible to make sure the medical care provider notifies Cigna by calling the Everence telephone number listed on your membership card prior to any outpatient spinal procedure that punctures the skin that is provided in a:

1. Hospital,
2. Ambulatory surgical facility (see definition in *Part II*),
3. Clinic, or
4. Doctor's office.

Cigna will certify by telephone and in writing:

1. The medical necessity for the service; and
2. The appropriateness of the facility where the service is being performed.

Note: certain Mayo Clinic providers who are preferred providers are not required to precertify spinal procedures that puncture the skin that are performed at Mayo Clinic. You are responsible to contact the claims administrator (Everence Insurance Company) at (800) 348-7468 to make sure these spinal procedures performed by Mayo Clinic providers at Mayo Clinic are covered by the plan. If the spinal procedure is not covered by the plan, you will be responsible to pay the entire cost of the procedure.

D. Concurrent Care Review

Cigna will monitor a covered person's inpatient stay and provide concurrent care review of the course of inpatient treatment and other medical services. Cigna will also coordinate discharge planning with the attending physician, the medical care facility, the patient, and the patient's family, providing for either the scheduled discharge from the inpatient facility, an extension of the inpatient stay, or cessation of approved medical services.

This plan will not pay for an inpatient stay or course of treatments that extends beyond the number of days or treatments Cigna has initially certified — unless an extension of a certified stay or treatment has been approved by Cigna.

E. Specialty Pharmaceuticals

You or your physician must obtain approval for all self- or physician-administered specialty pharmaceuticals (see definition in *Part II*) through CVS Caremark at (800) 237-2767 before treatment initially begins and the drugs are purchased. Specialty pharmaceuticals subject to this requirement include select oral, injectable, and infused medications that are biopharmaceuticals (bioengineered proteins), blood-derived products, and complex molecules. In general, specialty pharmaceuticals include, but are not limited to blood modifiers and drugs prescribed for the treatment of respiratory syncytial virus (RSV), growth hormone deficiency, Crohn's disease, hepatitis C, hemophilia, Gaucher's disease, cystic fibrosis, multiple sclerosis, rheumatoid arthritis, asthma, enzyme replacement, immune deficiencies, pulmonary arterial hypertension, and other chronic low prevalence diseases.

You or your physician must contact CVS Caremark at (800) 237-2767 to begin the approval process. You must purchase specialty pharmaceuticals from a Caremark specialty pharmacy, as directed by CVS Caremark, in order for the drugs to be covered by the plan. There is no deductible or coinsurance requirement for approved specialty pharmaceuticals purchased as directed by CVS Caremark from a Caremark specialty pharmacy.

If you do not obtain prior approval for specialty pharmaceuticals through CVS Caremark or if you do not purchase the drugs from a Caremark specialty pharmacy, as directed by CVS Caremark, there are no plan benefits and you will be responsible for the total cost of the drugs.

F. Reduced Benefits and Other Information

Failure to Precertify an Inpatient Admission, Transplant, or Applicable Spinal Procedure

If Cigna is not notified according to these precertification procedures or if you do not follow the instructions of Cigna, the benefits normally paid by the plan for an inpatient admission, transplant, or spinal procedure will be reduced by $250.

If Cigna Will Not Certify an Inpatient Admission, Transplant, or Applicable Spinal Procedure

If Cigna is notified according to these precertification procedures and the inpatient admission, transplant, or spinal procedure is not certified because it was determined not to be medically necessary, no charges in connection with the inpatient admission, transplant, or spinal procedure (facility charges, physician fees, etc.) will be eligible for coverage.

Failure to Precertify Specialty Pharmaceuticals through CVS Caremark

If you do not receive approval for purchase of specialty pharmaceuticals from CVS Caremark according to these precertification procedures or if you do not purchase specialty pharmaceuticals from a Caremark specialty pharmacy, as directed by CVS Caremark, there are no plan benefits and you will be responsible for the entire cost of purchasing the specialty pharmaceuticals.

G. Appeals

If there are any unresolved differences between the attending physician and Cigna or CVS Caremark regarding precertification, you have the right to appeal the precertification decision to the plan administrator (Mennonite Mission Network). To appeal an adverse precertification decision, you must contact Everence at (574) 533-9511 or (800) 348-7468 within 60 days following the day you are notified of the precertification denial. Everence will facilitate the appeal with the plan administrator. You will be notified of the plan administrator's decision as soon as possible, but no later than 30 days after your appeal is received by Everence.

H. Large Claims Management

Some injuries and illnesses have the potential to result in high medical expenses. Because the claims administrator (Everence) wants to assure the wisest possible use of your benefits and extend benefits as far as possible, large claims management is offered. This service works in partnership with you and the attending physician. It is provided as part of your benefits.

Characteristics
Some of the characteristics of large claims include:
1. Costs exceeding $15,000 with potential to reach $50,000 or more;
2. Conditions with more than 20 claims per year;
3. More than three hospital admissions per year;
4. Rehabilitation facility stay — of more than three-month duration; and
5. Home health care requiring 24-hour coverage.

Therapy/Treatments
Some of the therapies or treatments common to large claims include:
1. Hyperalimentation (TPN) and other nutritional support systems;
2. Extensive intravenous therapies — chemotherapy, antibiotic therapy, etc.;
3. Dialysis and CAPD (Continuous Ambulatory Peritoneal Dialysis);
4. Ventilators and sleep apnea monitors; and
5. Long-term medication use exceeding $10,000 per year.

Conditions
The following conditions often result in large medical expenses:
1. Premature birth,
2. Complicated pregnancies,
3. Spinal cord injury,
4. Major brain injuries and tumors,
5. Leukemia,
6. Cancer,
7. Multiple sclerosis,
8. Muscular dystrophy,
9. HIV diseases,
10. Chronic Fatigue Syndrome,
11. Severe burns,
12. Amputations,
13. ALS (amyotrophic lateral sclerosis),
14. Major heart conditions,
15. CVA — Cerebral Vascular Accident (severe stroke),
16. Severe trauma (auto accident, etc.),
17. Organ transplant,
18. Hemophilia, and
19. Diagnoses with long-term treatment plans.

Case Manager
A case manager will work with you and the attending physician to suggest alternatives to meet your needs. You and the attending physician decide what is best for your family — the case manager can only propose and act with your consent. Existing medical benefits will not be limited if you and the physician do not accept the case manager's recommendations.

Your case manager will also act as an information source for you, your family, and your provider on health care alternatives. He or she will act as a liaison with specialized facilities and providers, recommend local support groups, and suggest other ways to minimize stress.

Medically necessary alternative care recommended by the case manager not otherwise specifically covered by the plan, and not specifically excluded by the plan, that can be provided without impairing the quality of care may be considered an eligible expense if approved by:
1. The plan administrator (Mennonite Mission Network);
2. The covered person; and
3. The attending physician.

If the plan provides alternative benefits for a covered person in one instance, it will not obligate the plan to provide the same or similar benefits for any other covered person in any other instance, nor will it be construed as a waiver of the plan's right to administer the plan thereafter in accordance with its terms. In addition, if the plan provides alternate benefits for a covered person, it will not obligate the plan to provide the same benefits for the same person without prior approval and authorization.

How It Works
As soon as you become aware of an injury or illness that may result in high medical expenses, you need to call the claims administrator and a case manager will be assigned. Call (574) 533-9511 or (800) 348-7468. If you have already precertified an admission related to the claim, you do not need to contact the claims administrator.

If the case has potential for large claims, the case manager will contact your family and the physician to ask permission to work with the case. Following your contact and approval, the case manager will monitor the patient's status, working to give you the best possible support.

Part IX, Covered Services

This plan covers charges for services or supplies provided by medical care providers that are medically necessary and appropriate for the treatment of an injury or illness, provided these charges are not listed under *Part X*. To receive maximum benefits for an inpatient admission, transplant, applicable spinal procedures, and all specialty pharmaceuticals, the services **must** be precertified according to the precertification procedures outlined in *Part VIII*.

If services are not precertified as required or you do not follow the instructions of Cigna or CVS Caremark, payments will be reduced for all covered charges in connection with the claim. The benefits normally paid by the plan will be reduced as outlined in Part VIII, Section F.

A. Ambulance Services

The plan covers local transportation by a specially designed and equipped vehicle used only to transport the sick and injured:
1. From the patient's home to a hospital;
2. From the scene of an accident or medical emergency to a hospital;
3. Between hospitals; or
4. Between a hospital and a skilled nursing facility.

Local transportation is covered to the closest hospital or facility that can provide services appropriate to the patient's condition.

The plan also covers local transportation by a specially designed and equipped vehicle used to transport the sick and injured:
1. From a hospital to the patient's home; and
2. From a skilled nursing facility to the patient's home.

B. COVID-19 Testing and Related Services

Effective March 18, 2020 and for the duration of the public health emergency related to COVID-19, the plan covers diagnostic testing for COVID-19 and related items and services without applying cost-sharing requirements. Related items and services are those provided during a health care provider office visit (including telehealth visits), urgent care center visit, or emergency room visit that results in an order for or administration of COVID-19 testing. Related items and services are covered without cost sharing only to the extent the items and services relate to the furnishing or administration of COVID-19 testing or the evaluation of the individual's need for COVID-19 testing. The plan's normal out-of-network cost-sharing requirements will apply to unrelated items and services and expenses for COVID-19 treatment received from out-of-network providers.

C. Dental Services

The plan covers the following dental care:
1. An annual routine dental exam. **This benefit is not covered during the first year of service.**
2. Required dental services. **This benefit is not covered during the first year of service.**
3. Medical and surgical dental services provided in connection with treatment of an injury or illness, including:
    a. Treatment of sound natural teeth damaged by an accident; and
    b. Biopsies and oral surgery on lesions of the mouth.

The plan will pay up to a maximum of $300 per covered adult and $500 per family (adults only) each plan year for routine dental exams and required dental services combined with routine vision services (see *Part IX, Section W, items #1 and #2*). The plan-year maximum does not apply to covered persons under age 19. Medical and surgical dental services

provided in connection with treatment of an injury or illness are covered during the first year of service and are not subject to the plan-year maximum.

D. Diabetes Services

The plan covers the following services when required in connection with the treatment of diabetes:
1. Outpatient diabetes self-management training for the treatment of diabetes, diabetes education, and medical nutrition therapy services. These services must be ordered by a physician and provided by appropriately licensed or registered healthcare professionals. Outpatient diabetes education services will be covered subject to the claims administrator's criteria, which is based on certification programs for outpatient diabetes education developed by the American Diabetes Association (ADA).
2. Diabetic self-management equipment and supplies such as blood glucose monitors, monitor supplies, insulin infusion devices, insulin syringes, blood glucose and urine test strips, and lancets*.
3. Preventive foot care, including medically necessary diabetic shoes.

*Insulin syringes, blood glucose and urine test strips, and lancets are also covered under the *Outpatient Prescription Drug Rider* attached to this summary plan description.

E. Durable Medical Equipment

The plan covers purchase or rental (at the option of the claims administrator) of durable medical equipment used for therapeutic purposes. The plan covers rental charges up to a maximum equal to the purchase price of the equipment.

To be covered by the plan, durable medical equipment must be:
1. Ordered or provided by a physician for outpatient use;
2. Used for medical purposes;
3. Not consumable or disposable;
4. Not of use to a person in the absence of an illness, injury, or disability;
5. Durable enough to withstand repeated use; and
6. Appropriate for use in the home.

Examples of durable medical equipment include but are not limited to:
1. Equipment to administer oxygen;
2. Equipment to assist mobility, such as a wheelchair, walker, canes, and crutches;
3. Hospital beds;
4. Delivery pumps for tube feedings or IV infusions;
5. Burn garments;
6. Home or portable dialysis system; and
7. Equipment for treatment of chronic or acute respiratory failure or conditions.

F. Home Health Care

The plan covers home health care services furnished by a certified home health care agency (see definition in *Part II*) if a covered person requires care at home due to the nature of the patient's condition. To be covered by the plan, all of the following conditions must be met:
1. A physician must certify the need for part-time skilled nursing care, physical medicine, occupational therapy, speech therapy, or respiratory therapy;
2. A physician must set up the home health care plan (see definition in *Part II*) and order the services; and
3. The services must be provided by a registered nurse in the covered person's home or provided by a licensed practical nurse and supervised by a registered nurse in the covered person's home.

All services listed in *Part IX, Section U* and *Section X,* that are prescribed under the home health care plan set up by the attending physician are covered by the plan. Physical medicine, occupational therapy, and speech therapy services provided under a home health care plan are subject to the limitations outlined in *Part IX, Section U.*

The plan does not cover custodial care, homemaker services, respite care, or rest cures.

G. Hospice Care

The plan covers inpatient and outpatient hospice care services provided by a hospice care agency (see definition in *Part II*) to terminally ill individuals and family members as part of an approved hospice care program (see definition in *Part II*). All services listed in *Part IX, Section U* and *Section X* that are provided as part of a hospice care program are covered by

the plan. Physical medicine, occupational therapy, and speech therapy services provided as part of a hospice care program are subject to the limitations outlined in *Part IX, Section U.*

H. Hospital Services

The plan covers the following inpatient and outpatient services received in a hospital.

Covered Outpatient Hospital Services

1. Operating, recovery, and emergency rooms and equipment.
2. Emergency treatment of an accidental injury or a medical condition manifesting itself by acute symptoms that require immediate attention.
3. X-rays, laboratory tests, and other diagnostic services prescribed by the attending physician (see *Section J* in this *Part IX*).
4. Hospital services and supplies for outpatient surgery, including anesthesia and anesthesia supplies and services.
5. Surgical pathology.
6. Outpatient therapy and rehabilitation services. Physical medicine, occupational therapy, and speech therapy services are subject to the limitations outlined in *Part IX, Section U.*

Covered Inpatient Hospital Services

1. Room and board while confined in a semiprivate room of a hospital.
2. Room and board while confined in a special care unit where intensive care to the critically ill is provided.
3. Room and board while confined in a private room of a hospital. The private room allowance is the hospital's most common daily **semiprivate** room charge for each day of confinement in a private room.
4. Other services and supplies prescribed by the attending physician, such as:
   a. General nursing services;
   b. Operating, delivery, treatment, and recovery rooms and equipment;
   c. Anesthesia and anesthesia supplies and services provided in a hospital;
   d. Special diets;
   e. X-rays, laboratory tests, and other diagnostic services;
   f. Drugs and medicines;
   g. Oxygen;
   h. Blood and transfusions;
   i. Medical and surgical supplies such as casts, dressings, etc.; and
   j. Therapy and rehabilitation services.

I. Infertility Testing and Treatment

The plan covers diagnostic testing and treatment of the underlying cause of male sterility and female infertility (see definition in *Part II*). Diagnostic procedures include, but are not limited to, sperm count, endometrial biopsy, hysterosalpingography, and diagnostic laparoscopy.

The plan does not cover treatment provided specifically for the purpose of assisted fertilization (See item #45 in *Part X*).

J. Laboratory, X-ray, and Other Diagnostic Services

The plan covers laboratory, x-ray, and other diagnostic services for illness or injury-related diagnostic purposes when ordered by a physician and received on an outpatient basis at a hospital. Covered services include but are not limited to:

1. Laboratory tests and radiology/x-rays;
2. Mammography;
3. CT scans, PET scans, MRI/MRA, nuclear medicine studies, and other major diagnostic services;
4. Diagnostic and therapeutic scopic procedures for visualization, biopsy, and polyp removal (colonoscopy, sigmoidoscopy, and endoscopy);
5. Facility charges;
6. Charges for supplies and equipment; and
7. Physician services for anesthesiologists, pathologists, and radiologists.

The plan also provides benefits for laboratory, x-ray, and diagnostic services performed in a physician's office or urgent care facility (see *Section M* in this *Part IX*).

K. Mental Health Care Services

The plan covers mental health care services provided by mental health professionals (see definition in *Part II*) for the treatment of mental disorders (see definition in *Part II*). The plan covers services received on an inpatient basis in a

hospital or licensed facility specializing in such treatment and services received on an outpatient basis in a physician's office or licensed outpatient facility specializing in such treatment, including telehealth behavioral health visits (virtual video, and billable phone consultations) with a covered person's treating mental health professional. The plan covers the following services:

1. Inpatient hospital services;
2. Partial hospitalization;
3. Individual psychotherapy;
4. Group psychotherapy;
5. Psychological testing;
6. Medication checks;
7. Biofeedback;
8. Medical hypnotherapy; and
9. Electroshock treatment or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same mental health professional.

L. Orthotic Devices

The plan covers purchase, fitting, necessary adjustment, repairs, and replacement of rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part. Orthotic devices covered by the plan include, but are not limited to casts, splints, trusses, braces, and orthopedic shoes when part of a leg brace. The plan does not cover foot orthotic devices when not part of a leg brace.

M. Physician Charges

The plan covers the following physician services:

1. Office visits to a physician, specialist, or urgent care facility for:
   a. Evaluation and treatment of an illness or injury, including laboratory, x-ray, or other diagnostic services performed in a physician's office or urgent care facility;
   b. Administration of specialty pharmaceuticals (prior approval is required as outlined in *Part VIII, Section E*);
   c. Allergy injections; and
   d. Preventive health care services. Benefits for preventive health care services will be provided as outlined in *Section N* of this *Part IX*.
2. Telehealth visits (virtual, video, and billable phone consultations) with a covered person's primary care physician or treating specialist, or other physician or specialist in the medical group the primary care physician or specialist is part of.
3. Physician fees for surgical procedures and other medical care provided to a covered person while a hospital inpatient.
4. Medical or surgical (see *Part IX, Section T*) consultations that a physician qualified by special training or experience makes to help the attending physician diagnose or treat the covered person's condition.

N. Preventive Care Services

You must receive eligible preventive care services from a provider that is part of the Cigna PPO network for the charges to be paid by the plan. **If preventive care services are received from a provider that is not part of the Cigna PPO network, there are no plan benefits and you will be responsible to pay the charges. Some preventive care services are not covered during the first year of service, as indicated below.**

Adult Preventive Care Services

Adult preventive care services covered by the plan include, but are not limited to the following:

1. An annual routine physical exam and related tests for covered persons age 19 and older, including a complete medical history, height and weight measurement, complete blood count (CBC), urinalysis, and screening for alcohol misuse, depression, obesity, sexually transmitted diseases, and tobacco use. **This benefit is not covered during the first year of service.**
2. An annual gynecological exam, including a pelvic exam, pap test, and clinical breast examination. **This benefit is not covered during the first year of service.**
3. An annual routine mammographic screening starting at age 40 or as recommended by a physician. **This benefit is not covered during the first year of service.**
4. Well-woman visits to obtain preventive services. **This benefit is not covered during the first year of service.**
5. Routine diagnostic screenings and lab tests. The plan will not pay for any duplication of tests performed under both a routine physical exam and a routine gynecological exam. **This benefit is not covered during the first year of service.**

6. Routine prostate cancer screening, including an annual prostate specific antigen test and/or digital rectal exam. **This benefit is not covered during the first year of service.**
7. Routine adult immunizations, **not** including those required for travel to a foreign country.
8. As prescribed, all FDA-approved contraceptive methods (including sterilization, oral contraceptive drugs, transdermal contraceptive patches, contraceptive injectables, contraceptive implants, and contraceptive devices) for all women with reproductive capacity.
9. As prescribed, risk reducing breast cancer medications (Tamoxifen or Raloxifene) for women ages 35 and older without a cancer diagnosis who are determined by their physician to be at increased risk for breast cancer and at low risk for adverse medication effects.

Pediatric Preventive Care Services

Pediatric preventive care services covered by the plan include, but are not limited to the following:

1. Well child exams for covered persons under age 19, including a complete medical history, height and weight measurement, behavioral and developmental assessments, and screening for autism, depression, and obesity. **This benefit is not covered during the first year of service.**
2. Routine diagnostic screenings and lab tests. **This benefit is not covered during the first year of service.**
3. Routine pediatric immunizations, **not** including those required for travel to a foreign country.

O. Prosthetic Devices

The plan covers charges for the initial purchase and fitting of artificial limbs, eyes, larynx, braces, orthopedic shoes when part of a leg brace, and other prosthetic devices that replace a limb or body part or help an impaired limb or body part work (such as a heart pacemaker), as long as the device is ordered by a licensed physician. The plan does not cover dental devices.

For adults, the plan covers one replacement every three years if you submit a written statement from a licensed physician to the claims administrator verifying the prosthetic device is:

1. Sufficiently worn or defective; and
2. No longer providing its intended function.

The plan does not cover replacement of prosthetic devices that are necessary due to weight gain of fully matured adults.

For children and adolescents who have not yet achieved full growth, the plan covers charges for replacement of prosthetic devices that are necessary because the child or adolescent has grown. A written statement from a licensed physician must be submitted to the claims administrator verifying this is the reason the replacement is needed.

P. Second and Third Opinions

The plan covers expenses for second and third opinions at 100 percent when required by Cigna through precertification.

Q. Skilled Nursing Facility Services

The plan covers skilled nursing facility services for an inpatient stay in a skilled nursing facility (see definition in *Part II*) when a covered person requires skilled care (see definition in *Part II*) on a daily basis or treatment of an illness or injury that would otherwise require an inpatient hospital stay. Skilled nursing facility services must be medically necessary and appropriate and ordered by a physician. Covered charges include room, board, general nursing care, physician services, and rehabilitation services while confined in a skilled nursing facility if:

1. The nursing facility stay begins within 14 days after a hospital stay of at least three consecutive days;
2. The nursing facility stay is for the same injury or illness as the hospital stay;
3. A physician certifies that 24-hour nursing care is needed for the person's condition; and
4. The nursing facility's Utilization Review Committee or a Professional Standards Review Organization does not disapprove of the nursing facility confinement.

Skilled nursing facility services will be covered by the plan up to 100 days per plan year.

The plan does not cover charges for skilled nursing facility services:

1. After the patient has reached the maximum level of recovery possible for his or her specific condition and no longer requires definitive treatment other than routine supportive care;
2. When confinement in a skilled nursing facility is primarily custodial in nature and intended solely to assist the patient with activities of daily living or to provide an institutional environment for the patient's convenience; and
3. For treatment of mental disorders or substance abuse.

R. Spinal Manipulations

The plan covers spinal manipulations for the detection and correction, by manual or mechanical means, of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

Spinal manipulations are covered by the plan up to 20 visits per plan year.

Other treatment received in conjunction with spinal manipulations will be considered a physical medicine visit and will be subject to the physical medicine limitations listed in *Section U* of this *Part IX*.

S. Substance Abuse Services

The plan covers treatment of substance abuse (see definition in *Part II*) received on an inpatient basis in a hospital or licensed facility specializing in such treatment or received on an outpatient basis in a provider's office or licensed outpatient facility specializing in such treatment, including telehealth treatment visits with a covered person's treating mental health professional.

Covered services include the following:

1. Inpatient hospital services;
2. Diagnostic evaluations and assessment;
3. Treatment planning;
4. Medication management;
5. Individual, family, and group counseling;
6. Psychotherapy;
7. Partial hospitalization; and
8. Detoxification.

T. Surgical Services

The plan covers medically necessary surgical services in connection with the treatment of an illness or injury which is not work related. The plan covers the following:

1. Surgeon fees. If the surgeon visits a covered person in the hospital after surgery, such visits will be considered part of the fee for the surgery and not inpatient hospital visits;
2. Assistant surgeon fees, only if medically necessary;
3. Facility charges for operating and recovery rooms and miscellaneous medical supplies, such as dressings and bandages; and
4. Anesthesia and its administration, as long as the surgeon does not administer it.

Reconstructive Surgery Following a Mastectomy

The plan covers breast reconstruction in connection with a mastectomy, as provided in the Women's Health and Cancer Rights Act of 1998 which applies to this plan. Eligible charges include:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications from all stages of mastectomy, including lymphedemas.

The benefits under this provision will be provided in a manner determined in consultation with the attending physician and the patient.

U. Therapy and Rehabilitation Services

The plan covers charges for the following therapy and rehabilitation services when ordered by a physician for the necessary treatment of a covered person's condition:

1. Radiation therapy;
2. Chemotherapy;
3. Dialysis treatment;
4. Physical medicine (see definition in *Part II*), limited to 20 visits per plan year when received on an outpatient basis;
5. Respiratory therapy;
6. Occupational therapy, limited to 20 visits per plan year when received on an outpatient basis;
7. Speech therapy, limited to 20 visits per plan year when received on an outpatient basis;
8. Infusion therapy; and
9. Cardiac rehabilitation.

The plan does not cover therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate.

Exception

The annual visit limits will not apply if, following an authorized hospitalization or outpatient surgical procedure, a covered person needs physical medicine, occupational therapy, or speech therapy due to burns, strokes, traumatic brain injuries or spinal injuries, degenerative diseases, complete dislocations, major fractures, ligament replacements, or joint replacements.

However, if it is necessary to continue outpatient therapy for any of the above conditions beyond the visit limit, you will need to obtain approval for the continuing treatment from the claims administrator (Everence) in advance.

A weekly written treatment plan, including proposed outcomes of therapy, must be part of this approval process. Services will no longer be considered eligible when measurable progress toward expected outcomes has reached a plateau or is inconsistent as determined in consultation with the attending physician.

V. Transplants – Organ and Tissue

To receive maximum benefits, transplants must be precertified by Cigna, in advance (see *Part VIII, Section B*). The covered person's physician may contact Cigna by calling the Everence Insurance Company telephone number listed on your membership card to begin this process.

Charges for medically necessary human organ, bone marrow, and tissue transplants will be covered as any other illness if Cigna has approved the procedure before the donor search and selection has been done, and if the following conditions are met:

1. The procedure or organ transplant is not considered experimental or investigational in nature by any appropriate technological assessment body established by any state or federal government;
2. The procedure is generally accepted and proven transplant procedure by the Federal Office of Health Technology Assessment, National Cancer Institute, or National Institutes of Health; and
3. Such expenses are not covered under any government or other insurance program.

Organ and bone marrow transplants include the following procedures:

1. Heart transplants;
2. Heart/lung transplants;
3. Kidney transplants;
4. Liver transplants;
5. Bone marrow transplants (autologous, allogeneic) or other method of stem cell support, if it is not experimental;
6. Lung transplants (single or double); and
7. Kidney/pancreas transplants from the same donor.

When an organ or bone marrow transplant procedure is approved, Cigna will recommend, in consultation with the covered person's physician, that the transplant be performed in a designated facility. A facility is designated when it appears on Cigna's list of centers designated for the specific transplant being performed. Designated facilities are those that have demonstrated proficiency in a specific transplant procedure. The credentials of each facility are reviewed annually.

Transplant Expenses

Covered charges for transplants are limited to charges that would qualify as covered expenses under this *Part IX* for:

1. Pre-transplant evaluation,
2. Pre-transplant harvesting,
3. Pre-transplant stabilization,
4. The transplant itself, and
5. Follow-up biopsies and anti-rejection medication.

Transplant Donor Expenses

Charges incurred by a live donor and not covered by any other plan of insurance will be covered as if they were the medical expenses of the covered person if:

1. The covered person received an organ or tissue of the live donor;
2. The transplant was covered by the plan; and

3. The transplant was approved by Cigna.

Donor expenses are covered only if the transplant recipient is a covered person under this plan and such services are not payable under any other plan.

Travel and Lodging Expenses

If an organ or bone marrow transplant is performed in a designated facility as recommended by Cigna in consultation with the physician, the plan will provide:

1. Transportation for the covered person and one adult to accompany the covered person to and from the transplant facility; and
2. Lodging at or near the transplant facility for the adult who accompanied the covered person, while the covered person is confined at the transplant facility.

Transportation and lodging for the accompanying adult will be limited to $5,000 per covered transplant at the transplant facility. Travel and lodging benefits are not available for tissue transplants.

This transportation and lodging will be provided for:

1. Pre-transplant evaluation, harvesting, and stabilization, and
2. The transplant itself.

The covered person is responsible to make transportation and lodging arrangements and submit the expenses to Everence for reimbursement. The plan will reimburse the costs at 100 percent up to the per transplant maximum.

Exclusions

No benefits will be paid for human organ, bone marrow, and tissue transplant charges:

1. For animal to human transplants;
2. For artificial or mechanical devices designed to replace human organs temporarily or permanently, if approved by Cigna;
3. For procurement or transportation of the organ or tissue unless expressly provided for in this provision;
4. To keep a donor alive for the transplant operation; and
5. That are excluded in *Part X* of this document.

W. Vision Services

The plan covers the following vision services and supplies when provided by an ophthalmologist, optometrist, physician, or optician:

1. An annual eye examination. **This benefit is not covered during the first year of service.**
2. Prescription lenses (glasses/contact lenses). **This benefit is not covered during the first year of service.**
3. Medical and surgical vision services provided in connection with treatment of an injury or illness, including the first set of corrective lenses needed after cataract surgery.

The plan will pay up to a maximum of $300 per covered adult and $500 per family (adults only) each plan year for eye examinations and prescription lenses combined with dental exams and required dental services (see *Part IX, Section C,* items #1 and #2). The plan-year maximum does not apply to covered persons under age 19. Medical and surgical vision services provided in connection with treatment of an injury or illness are covered during the first year of service and are not subject to the plan-year maximum.

X. Other Covered Charges

The plan covers the following types of care, service, and treatment given to a covered person in connection with a covered illness or injury:

1. Medical care, treatment, services, and supplies listed below, when prescribed by the attending physician:
    a. Use of radium or other radioactive substances.
    b. Whole blood or blood derivatives and the cost of its administration.
    c. Colostomy or ileostomy bags and related supplies.
    d. Private duty nursing provided by a registered nurse, licensed practical nurse, or licensed vocational nurse who is not an immediate family member and who does not normally live with you.
    e. Cosmetic surgery or procedures but only when performed to correct:
        - A congenital defect;
        - A condition resulting from an accidental injury; or
        - A functional impairment resulting from a covered illness or injury.

   f. Allergy testing and injections.
   g. Oxygen.
2. Elective sterilization for covered males, regardless of medical necessity and appropriateness. Elective sterilization for females is covered under the Adult Preventive Care Services provision outlined in *Part IX, Section N*.

Part X, Exceptions & Limitations — What Is Not Covered

Although the plan covers charges for most illnesses and injury, there are some conditions and charges it does **not** cover. These are:

A. Illness, Injuries and Other Services

The plan does **not** cover the following:
1. Care, services, treatment, or supplies that are not medically necessary or appropriate.
2. Charges in excess of the reasonable and customary (R&C) charge when services are received from an out-of-network provider.
3. Charges considered to be unbundled and which should have been included as part of a single global fee for a service, treatment, or procedure.
4. Charges billed with inappropriate or non-standard codes, as determined by the claims administrator according to accepted industry billing standards.
5. Care, services, treatment, or supplies received before a covered person's effective date of coverage under this plan or after coverage under this plan terminates.
6. Care, services, treatment, or supplies not prescribed by a physician.
7. Medical supplies and equipment purchased from non-credentialed suppliers (including on-line suppliers).
8. Care, services, treatment, or supplies for which you would not be required to pay if you didn't have this coverage.
9. Treatment of a condition resulting from or prolonged by involvement in an illegal occupation, performance of, or attempted performance of an assault or other felony.
10. Personal, non-medical services or supplies while hospitalized — for example, television, haircuts, telephone, and newspapers.
11. Reversal of an elective sterilization.
12. A hospital admission in connection with surgery that begins on a Fri., Sat., or Sun. — unless surgery is performed the next day. If a covered person is going to have surgery on Mon., the plan will cover an admission that begins on Sun.
13. Transplants other than those listed under *Part IX, Section V,* unless approved by Cigna.
14. Services, treatment, or supplies that are experimental or investigative for the condition being treated. That is, procedures and drugs that have not been adopted for general, clinical use and have not been approved by the appropriate boards or are not accepted by the medical community as safe, effective treatment.
15. Treatment or care of a condition that results from participating in a civil insurrection, riot, or duty as a member of the armed forces of any country or state at war.
16. Treatment or care of an illness or injury developed as the result of any work for wage or profit, except as provided in *Part VI*.
17. Charges made by a rest home or similar establishment, except as provided in this plan for a skilled nursing facility.
18. Custodial care that includes care that is chiefly for the purpose of meeting personal needs and that could be provided by individuals without professional skills or training.
19. Treatment for conditions that do not meet the level of impairment or symptoms required to be medically necessary such as, but not limited to:
    a. Partnership relationship problems;
    b. Marital counseling (if no mental health diagnosis);
    c. Parent-child problems; and
    d. Academic problems.
20. Care, services, treatment, or supplies given to you or a covered dependent by an immediate family member or someone who ordinarily lives with you.
21. Care, services, treatment, or supplies provided by or on behalf of any government agency unless you are obligated by law to pay the charges.
22. Dental x-rays, appliances, surgery, or treatment on or to the teeth, gums, or jaw, except as specifically covered in *Part IX, Section C*.
23. Orthodontic services, including consultations and braces.
24. Extraction of wisdom teeth.
25. Tooth implantology.
26. Cosmetic surgery or procedures, except as specifically covered in *Part IX, Section X, item #1e*.

27. Cosmetic foot care.
28. Smoking treatment programs.
29. Hearing tests, hearing services, purchase or fitting of hearing aids, and batteries for hearing aids.
30. Treatment of refractive errors, including, but not limited to, radial keratotomy procedures, keratomileusis (lasik), and other forms of surgery; and any vision services or supplies except:
    a. Eye exams, as specifically covered under *Part IX, Section W* (vision services);
    b. Purchase or fitting of eyeglasses or contact lenses, as specifically covered under *Part IX, Section W* (vision services); and
    c. Services provided in connection with medical or surgical treatment of an injury or illness.
31. Any vision lenses that do not require a prescription.
32. Prescription sunglasses.
33. Physical examinations not necessary for the treatment of an injury or illness, except as specifically covered in *Part IX, Section N.*
34. Any care related to conditions such as autism, hyperkinetic syndromes, learning disabilities, behavioral problems, or intellectual disabilities that extends beyond traditional medical management. Care that extends beyond traditional medical management includes the following:
    a. Services that are primarily educational in nature;
    b. Neuropsychological testing and educational testing (such as I.Q., mental ability, achievement, and aptitude testing), except for specific evaluation purposes directly related to medical treatment;
    c. Services provided for purposes of behavioral modification and/or training;
    d. Services related to learning disorders or learning disabilities;
    e. Services provided primarily for social or environmental change unrelated to medical treatment;
    f. Developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the covered person has not yet attained; and
    g. Services provided for which, based on medical standards, there is no established expectation of achieving measurable improvement in a reasonable and predictable period of time.
35. Repetition of diagnostic tests obtained for a second or subsequent surgical opinion.
36. Maternity services, including prenatal and delivery expenses.
37. Elective abortions for any reason other than to preserve the person's life upon whom the abortion is performed.
38. Services, supplies, and surgeries for the treatment of temporomandibular joint disorders, whether treated for a medical, dental, or psychological diagnosis.
39. Cardiac maintenance programs.
40. Diagnostic testing and treatment of sexual dysfunction, regardless of cause.
41. Treatment, surgery, supplies, instructions, or activities for obesity, morbid obesity, weight reduction, weight control, or physical fitness, even if medically necessary and prescribed or provided by a physician.
42. Exercise programs and equipment for treatment of any condition, except for physician-supervised cardiac rehabilitation programs, physical medicine, and occupational therapy specifically covered by this plan.
43. Acupuncture.
44. Food of any kind, including, but not limited to:
    a. Enteral formulae and other nutritional and electrolyte formulas, unless they are the only source of nutrition or are prescribed solely for the therapeutic treatment of phenylkentonuria or other inborn errors of metabolism;
    b. Infant formulas and donor breast milk;
    c. Foods to control weight, treat obesity (including liquid diets), lower cholesterol, or control diabetes;
    d. Oral vitamins and minerals; and
    e. Any other dietary or electrolyte supplement.
45. Treatment leading to or in connection with assisted fertilization such as, but not limited to:
    a. Artificial insemination,
    b. In-vitro fertilization (IVF),
    c. Gamete intrafallopian transfer (GIFT), and
    d. Zygote intrafallopian transfer (ZIFT).
46. Treatment for complications arising from or connected in any way with a surgical or medical treatment or procedure that is not covered by this plan, whether or not the patient was covered by this plan at the time the non-covered surgery, treatment, or procedure was performed.
47. Drugs not approved by the U.S. Food and Drug Administration for sale in the U.S.
48. Non-prescription drugs, medicines, dietary supplements, and first aid supplies.
49. Health services provided in a foreign country, unless required as emergency health services.

Part XI, How to File a Claim

A. Medical Services Received from a Network Provider

When medical services (including medical and surgical dental and vision services related to treatment of an illness or injury) are received from a medical care provider within the Cigna PPO network, you will not have to file a claim. The medical care provider will submit the claim to Cigna for you. You need to make sure you show your membership card to the provider. The provider will take the information needed and will then bill the plan. Any ineligible and unpaid services will be billed to you by the network provider.

B. Medical Services Received from an Out-of-Network Provider

If medical services (including medical and surgical dental and vision services related to treatment of an illness or injury) are received from a medical care provider that is not part of the Cigna PPO network, you or your provider must file a claim before the plan can pay the charges for a covered person's care, service, or treatment. It is your responsibility to make sure a claim for services received from an out-of-network provider is submitted to Cigna as outlined below in *Section E*.

C. Routine Dental and Vision Services Received from an In- or Out-of-Network Provider

You are responsible to file a claim for routine dental and vision services (eye exams, prescription lenses, dental exams, required dental services) with the claims administrator (Everence) as outlined below in *Section E*, regardless of whether the routine services are received from an in- or out-of-network provider.

D. Outpatient Prescription Drugs

You do not need to file a claim for outpatient prescription drugs that have been purchased with your membership card. The drug charges will be submitted automatically to the claims administrator.

E. Filing a Claim

To be considered for payment, a claim must be filed within one year from the date of service. **A claim filed more than one year after the date of service is not eligible for coverage.**

To file a claim for medical services (including medical and surgical dental and vision services related to treatment of an illness or injury), you must send the itemized bill furnished by the medical care provider to Cigna at the address on the back of your membership card.

To file a claim for routine dental and vision services (eye exams, prescription lenses, dental exams, required dental services) you must send the itemized bill furnished by the vision or dental provider to Everence.

It is important to send in the original bill. "Balance due" statements, paid receipts, or canceled checks cannot be used because they do not provide enough information for the claim to be processed correctly. When presenting the bill to Cigna or the claims administrator (Everence) for reimbursement, you will need to make sure the following information is included:

1. The Group number listed on the front of your membership card;
2. The Member number listed on the front of your membership card;
3. The full name of the patient;
4. The provider's name and address;
5. A description of the care, service, or treatment provided, showing the cost and itemized by date; and
6. Diagnosis of the illness, injury, or condition.

After the claim is processed, you will receive an *Explanation of Benefits*. Please read it carefully so you will understand how the claim has been paid. This form lists:

1. The total amount billed;
2. The total amount not covered by the plan and the reason it was not covered;
3. The total amount paid;
4. Who was paid;
5. For whom it was paid; and
6. A description of the care, service, or treatment given.

Part XII, When a Claim Is Not Paid

If you file a claim and it is not paid or part of it is not paid and you think it should be, you can ask for a review. To do this, follow these steps:

1. If after reviewing your *Explanation of Benefits*, it is unclear to you how a claim was paid or why all or part of a claim was not paid, please contact the claims administrator (Everence) for clarification.
2. If after talking with Everence, your question or concern is not addressed to your satisfaction, put your concern in writing. A *Request for Claim Review* form is available through the plan representative or Everence. After completing the form, return it along with a copy of the *Explanation of Benefits* (keep the original for your records) to Everence. You need to present your request for review within 60 days after you receive the *Explanation of Benefits*.
3. Everence may need to review your concern directly with the plan administrator (Mennonite Mission Network). You will receive a written response to your request for review within 60 days after the request is received. If more time is required, you will be notified.

Mennonite Mission Network, as the plan administrator, has the power and final discretionary authority to interpret the provisions of the plan. It is part of their job to determine eligibility for benefits and determine how benefit provisions are to be applied. Their decisions apply to all plan participants regardless of special circumstances. Decisions will be applied in the same way for all individuals covered by the plan.

You cannot file a lawsuit on any claim the plan does not pay (whether all of the claim or part of it) unless you have taken the steps listed above. You also cannot file a lawsuit on any claim until at least 60 days after the claim has been properly filed and not more than three years after the care, service, or treatment has been given to you or your covered dependent.

Part XIII, When Coverage Ends

Effective March 18, 2020, coverage may be extended for up to 60 days for MVS participants who are furloughed or unable to continue their MVS service assignment due to the impact of the COVID-19 public health emergency. If an MVS participant is unable to resume their MVS service assignment on the first business day that follows the last day of the 60-day extension, coverage under the plan will terminate, unless the MVS participant purchases the Extended Coverage option of the plan, as outlined below in the paragraph entitled *Extended Coverage*.

Plan coverage for you and your dependents will end at midnight on the first of the following events:

1. The last day of your MVS service assignment with Mennonite Mission Network;
2. The day that is eight weeks after you are unable to continue your MVS service assignment due to a medical condition;
3. The day that is eight weeks after you are unable to continue your MVS service assignment due to the circumstances of a non-medical leave allowed by the Leave policy outlined in the MVS Policy Handbook and approved by Mennonite Mission Network; or
4. The day the plan sponsor terminates the plan for all plan participants.

Coverage for your dependent child will also end the last day of the month in which your child no longer qualifies as your dependent; for example, if your child reaches the age limit described in *Part III*.

Coverage for your spouse will also end the day your spouse gains access to group health plan coverage sponsored by or provided by his or her employer, regardless of whether your spouse enrolls in the coverage.

Coverage for your spouse following divorce or legal separation will end on the first of the following events:

1. The day a legal separation is officially recognized in a state that recognizes legal separation;
2. The day the divorce is final; or
3. The date determined by Mennonite Mission Network, which is no later than six months after the volunteer and spouse no longer share the same domicile.

Plan coverage will end as described above unless you or your dependents choose to extend coverage entirely at your own cost as allowed below.

Extended Coverage

If you are covered under this plan during the term of your MVS service assignment, you may purchase extended plan coverage for a minimum of 21 days and a maximum of six months after plan coverage would otherwise terminate at the end of your assignment or eight weeks after you are unable to continue your MVS service assignment due to a medical

condition or the circumstances of a non-medical leave of absence. Extended coverage is provided as a temporary transition until alternate health coverage can be arranged and take effect. Extended coverage is not available to you if, at the time your MVS service assignment ends, you are:

1. Eligible for or enrolled in another group health plan;
2. Enrolled in an individual health plan; or
3. Eligible for or entitled to (enrolled in) Medicare.

If you enroll in extended coverage, you may also enroll your covered spouse and children as long as they continue to qualify as your dependents, according to the terms of this plan. If you do not enroll in extended coverage, your spouse and dependents are not eligible for extended coverage.

To enroll in extended coverage, you must inform the plan representative of your desire to extend coverage within 14 days following the date your coverage under this plan would otherwise end at the end of your assignment or eight weeks after you are unable to continue your MVS service assignment due to a medical condition or the circumstances of a non-medical leave of absence. If you do not inform the plan representative of your desire to extend coverage within 14 days following the termination date, you will lose all rights to extended coverage under this plan.

Extended coverage will begin the day after plan coverage would otherwise end and will be the same coverage that the plan provides to other plan participants who are enrolled as MVS participants. You will have the same rights and benefits under the plan as other plan participants, including special enrollment rights.

You may contact the plan representative to determine the required premium for extended coverage. The premium for extended coverage is determined each year on Oct. 1 and remains the same for the next year. It is based on the amount paid for claims during the previous year and the costs of administering the plan.

Extended coverage will end upon the earliest of the following events:

1. Six months following the date extended coverage became effective;
2. The last day of coverage for which you paid the required premium;
3. The day you or your dependent become eligible for or covered under any other group health plan;
4. The day you or your dependent become covered under any individual health plan;
5. The day you or your dependent become eligible for or entitled to (enrolled in) Medicare; or
6. The day Mennonite Mission Network terminates the plan for all plan participants.

If you do not enroll in extended coverage, group health coverage under this plan will end as outlined above.

This benefit requires Mennonite Mission Network to keep careful records on all MVS participants and their dependents. Remember, it is your responsibility to let the plan representative know the last day of your MVS service assignment and the status of alternate health coverage you have applied for. You must also inform the plan representative when any of your personal information changes, such as your address, your marital status, the number of dependents you have, their names and birth dates, etc.

If you have any questions about extended coverage, please contact the plan representative.

Part XIV, Coordination of Benefits

If you or someone in your family are covered by this plan and another health plan or any other insurance, the two plans coordinate benefits. If more than two plans are involved, all plans will be taken into account. The intent is to avoid paying twice on the same service while providing covered individuals with the benefits outlined in this summary plan description.

To coordinate benefits, one plan (the primary plan) pays benefits first, and the other plan (the secondary plan) pays if there are allowable expenses not paid by the first plan.

A. Definition of Plan

To coordinate benefits, a plan is defined as providing benefits, treatment, or services for medical or dental care. It includes the following:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage. It also includes coverage other than school accident-type coverage.

2. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, grants to states for Medical Assistance Programs of the U.S. Social Security Act, as amended from time to time).
3. Motor vehicle insurance (including no-fault auto insurance).

Each contract or other arrangement for coverage under #1, #2, or #3 is a separate plan. Also, if an arrangement has two parts and coordination of benefit rules apply to only one of the two, each of the parts is a separate plan.

Medicaid is not a plan under this provision.

B. Determining Which Plan is Primary

The following plans or programs will be deemed to be primary:
1. Plans that do not have a coordination of benefits provision;
2. Coverage that is required by law; and
3. Motor vehicle insurance coverage.

Otherwise, one of the following rules will apply.

If Covered under One Plan as an Employee and Another Plan as a Dependent

If you are covered by one plan as an employee, volunteer, member, or subscriber, and by another plan as a dependent, the plan you are covered by as an employee will be the primary plan.

If you are covered under a retiree plan, are on Medicare, and also have coverage as a dependent on your working spouse's plan, then:
1. The plan covering you as a dependent on your spouse's plan is the primary plan;
2. Medicare pays second; and
3. The plan covering you as a retiree pays last.

Active/Inactive Employee

The benefits of a plan that covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and as an employee. If the plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage

If a person whose coverage is provided under a right of continuation provided by federal or state law is also covered under another plan, the order of benefits will be determined as follows:
1. First, the benefits of a plan covering the person as an employee, volunteer, member, or subscriber (or as that person's dependent);
2. Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the plan that covered an employee, volunteer, member, or subscriber longer is the primary plan.

If a Dependent Is living with Both Parents and Has Coverage under Both Parents' Plans

1. The plan of the parent whose birthday falls earlier in a year will be the primary plan.
2. If the parents have the same birthday, the plan that has covered the parent the longest will be the primary plan.

If a Dependent's Parents are Divorced or Separated and the Dependent Has Coverage under Two Plans

Determining the primary plan is done in the following order:
1. If a court has decreed that one parent is responsible for the health care expenses of the child, that parent's plan will be primary;
2. If a court has awarded joint custody without specifying who has responsibility for the child's health care expenses, the birthday rule will apply;
3. If there is no court ruling as stated in #1 and #2, the plan of the parent with custody will be primary;
4. Next, the plan of the spouse of the parent with custody will be primary;

5. Finally, the plan of the parent not having custody will be primary.

C. When This Is the Primary Plan

Benefits will be paid as described in this summary plan description.

D. When This is the Secondary Plan

The plan will pay benefits only on allowable expenses that have not already been paid by the primary plan.

E. General Provisions

Definition of Allowable Expenses

An allowable expense means a necessary, reasonable, and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. Outpatient prescription drugs are not included as an allowable expense.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

Claim Determination Period

The claim determination period is a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or any part of a year before the date this coordination provision or a similar provision takes effect.

Right to Exchange Information with the Other Plan

To coordinate benefits, the claims administrator has the right to exchange information with the other plan and require you to supply any information needed. In addition, the claims administrator may pay other plans any amounts found necessary and deem these payments as paid benefits.

Benefits Other than Cash

If the primary plan offers benefits other than cash, the claims administrator will assign these a reasonable cash value and regard them a paid benefit.

Overpayment of Benefits

If as a result of this coordination of benefits provision, the amount of benefits paid by this plan on behalf of you or your dependents is more than should have been paid, the claims administrator may recover the overpayment on behalf of this plan. The claims administrator may recover the overpayment from:
1. You,
2. Your dependents,
3. Insurance companies, or
4. Other organizations.

Part XV, Provision of Protected Health Information to Plan Sponsor

A. Permitted and Required Uses and Disclosure of Protected Health Information (PHI)

Unless otherwise permitted by law, and subject to the conditions of disclosure outlined in *Section B* of this *Part XV* and obtaining written certification pursuant to *Section C* of this *Part XV*, the plan may disclose PHI or electronic PHI to the plan sponsor, provided the plan sponsor uses or discloses such PHI or electronic PHI only to perform plan administration functions which the plan sponsor performs on behalf of the plan.

Plan administration functions do not include functions performed by the plan sponsor in connection with any other benefit or benefit plan of the plan sponsor or any employment-related actions or decisions. Enrollment and disenrollment functions performed by the plan sponsor are performed on behalf of plan participants and beneficiaries and are not plan administration functions. Enrollment and disenrollment information held by the plan sponsor is held in its capacity as a company and is not PHI.

Notwithstanding the provisions of this plan to the contrary, in no event shall the plan sponsor be permitted to use or disclose PHI or electronic PHI in a manner that is inconsistent with 45 CFR §164.504(f).

B. Conditions of Disclosure for Plan Administration Purposes

Protected Health Information

The plan sponsor agrees that with respect to any PHI disclosed to it by the plan (other than enrollment/disenrollment information, summary health information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508 which are not subject to these restrictions), the plan sponsor shall:

1. Not use or further disclose the PHI other than as permitted or required by the plan documents or as required by law.
2. Ensure that any agents, including a subcontractor, to whom it provides PHI received from the plan, agree to the same restrictions and conditions that apply to the plan sponsor with respect to such PHI.
3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or benefit plan of the plan sponsor.
4. Report to the plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware.
5. Make available to a plan participant who requests access, the plan participant's PHI in accordance with 45 CFR §164.524.
6. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526.
7. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.
8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the plan available to the Secretary of Health and Human Services for purposes of determining compliance by the plan with 45 CFR §164.504(f).
9. If feasible, return or destroy all PHI received from the plan that the plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
10. Ensure that the adequate separation between the plan and the plan sponsor (i.e., the firewall) required by 45 CFR §164.504(f)(2)(iii) is satisfied.

Electronic Protected Health Information

The plan sponsor further agrees that if it creates, receives, maintains, or transmits electronic PHI (other than enrollment/disenrollment information, summary health information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508 which are not subject to these restrictions) on behalf of the plan, the plan sponsor will:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the plan.
2. Ensure that the adequate separation between the plan and the plan sponsor (i.e., the firewall), required by 45 CFR §164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information.
4. Report to the plan any security incident with respect to electronic PHI of which it becomes aware.

C. Certification of Plan Sponsor

The plan shall disclose PHI to the plan sponsor only upon the receipt of a certification by the plan sponsor that the plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the plan sponsor agrees to the conditions of disclosure set forth in *Section B* of this *Part XV*.

D. Permitted Uses and Disclosure of Summary Health Information

The plan may disclose summary health information to the plan sponsor, provided the plan sponsor requests such summary health information for the purpose of:

1. Obtaining premium bids from health plan providers for providing health insurance coverage under the plan; or
2. Modifying, amending, or terminating the plan.

E. Adequate Separation Between the Plan and the Plan Sponsor

The plan sponsor shall only allow the following employees to have access to protected health information:

1. Plan representative;
2. Mennonite Mission Network Senior Executive for Finance;
3. Members of the Health Plan Committee; and
4. Finance Assistant.

No other employees or individuals shall have access to PHI. Such employees shall only have access to and use of PHI to the extent necessary to perform the plan administration functions that the plan sponsor performs for the plan. In the event that any such employees do not comply with the provisions of this *Part XV*, the employee shall be subject to disciplinary action by the plan sponsor for non-compliance pursuant to the plan sponsor's employee disciplinary and termination procedures.

The plan sponsor shall ensure that the provisions of this *Part XV* are supported by reasonable and appropriate security measures to the extent the employees designated in this *Section E* create, receive, maintain, or transmit electronic PHI on behalf of the plan.

F. Definitions

For purposes of this *Part XV*, the following terms shall have the meaning set forth below unless otherwise provided by the plan:

Electronic protected health information (electronic PHI) — Protected health information that is transmitted by or maintained in any electronic media.

Plan sponsor — The plan sponsor of the plan is Mennonite Mission Network.

Protected health information (PHI) — Information that is created or received by the plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Protected health information includes information of persons living or deceased.

The following components of a member's information also are considered PHI: a) names; b) street address, city, county, precinct, zip code; c) dates directly related to a member, including birth date, health facility admission and discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/ license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code.

Summary health information — Information: a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under the plan; and b) from which the information described at 45 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

Part XVI, Other Important Points

A. Open Enrollment Period

Each year the plan provides an open enrollment period between June 1 and July 15. At that time, late enrollees have the opportunity to enroll in this plan. To enroll for coverage, the *Enrollment for Voluntary Service Health Plan* form must be completed and returned to the plan representative before the end of the open enrollment period. Coverage will be effective the following Aug. 1.

B. Subrogation

Subrogation means the plan's right to reimbursement — for loss under this summary plan description — for amounts you or any covered person recover for the same loss from any person or organization. It also means the plan's right to attempt

to recover the amount of payment, including the right to initiate or intervene in legal proceedings. No person shall take or do anything to defeat the plan's rights to recovery or rights of subrogation.

Subrogation applies to all claims, demands, actions, and rights of recovery you or any covered person may have against a third party or parties and the third party's insurers for a covered person's illness or injury. The plan's subrogation rights apply to your own or any covered person's uninsured motorist, underinsured motorist, or no-fault automobile insurance coverage, too. You must reimburse the plan on whatever amount of money is received.

If the plan pays any benefits for a covered person because of an injury or illness that was caused by a third party, then the plan will pay benefits on the condition and with the agreement and understanding that you will reimburse the plan for the amount of benefits paid (including costs and legal or attorney's fees in recovering the money) from the amount you or any covered person recover from the third party.

The plan shall be reimbursed in full in first priority from any monies to the extent of any and all benefits paid by the plan. You will not be required to reimburse the plan for more than you or any covered person receive by way of settlement or recovery on a judgment. If you or any covered person recover less than the plan has paid, you will not have to pay any additional money out of your pocket. If you or any covered person recover more than the plan has paid, you will be entitled to keep the difference between what was recovered and what the plan has paid.

If you or any covered person have a claim against a third party for a covered person's illness or injury, do not sign any releases or other papers that may compromise the plan's right to reimbursement or subrogation. **Be sure to check with the plan administrator (Mennonite Mission Network) before any papers are signed.** Any covered person must not hinder the plan's attempts to recover or resolve the claim with the third party unless the plan gives prior written consent. Because of payments the plan makes on behalf of individuals covered under the plan, you or any covered person have an obligation to cooperate fully with the plan administrator in their efforts to seek reimbursement or recovery from a third party.

C. No Contract of Employment

The plan does not constitute a contract of employment between the volunteer and Mennonite Mission Network. Mennonite Mission Network's rights with regard to disciplinary action and termination of any volunteer, if necessary, are in no manner changed by participation in this plan or any provision of it.

D. Overpayment

If for some reason the plan pays you more than you are entitled to, the plan has the right to subtract the overpayment from payments made to you or a medical care provider on your behalf in the future.

E. Right to Examine

If you or your dependent file a claim for benefits under this plan, the plan administrator (Mennonite Mission Network) or the claims administrator (Everence) shall have the right to ask the person to be examined by a physician of its choice. In this case, the plan will pay the full cost of the requested examination.

F. Periodic Information Requests

In order to keep plan information up-to-date, the plan administrator (Mennonite Mission Network) or the claims administrator (Everence) may request basic information about you or your covered dependents that is required to pay claims according to plan provisions.

G. Assignment

The benefits provided by the plan are intended to provide for your family's health care needs. Therefore, you may not assign any of the benefits to which you may be entitled under the plan to any person or organization unless that person or organization has provided health care services to you or a covered member of your family.

H. Facility of Payment

The plan will pay its benefits directly to the covered person's medical care provider (physician, hospital, etc.) if you sign a valid assignment of benefits. There is an *Assignment of Benefits* on the form used by the medical care provider to file the claim. This is where you should sign to allow the plan to pay the medical care provider directly.

I. Payment of Claims

The plan may require proof of payment before reimbursing you for claims that were not assigned to a medical care provider.

If the claims administrator (Everence) determines that a valid release cannot be given for payment of plan benefits, the claims administrator may, at its discretion, pay the individual who has assumed responsibility for your principal support and care. Because he or she has paid for your support and care, it is only fair for the plan to make payment to him or her.

If you should die before benefit payments have been made, the claims administrator may honor assignments you made before your death.

Any payment made by the claims administrator in accordance with this provision shall fully satisfy its liability for payment.

J. Misrepresentation

If your or your dependent intentionally misrepresent a material fact (either verbally or in writing) or commit fraud and because of that misrepresentation or fraud, coverage is given to an individual who would otherwise not be eligible for coverage, the plan has the right to rescind coverage from the date it became effective and pursue recovery of any benefits received. At least 30 days advance notice will be provided before plan coverage is rescinded.

Likewise, if a covered person knowingly makes a statement, either verbally or in writing, which is not true and because of that statement, a claim that would otherwise not be eligible for payment is paid, the plan has the right to pursue recovery of benefits received by the covered person as a result of the claim.

K. Clerical Error

Any clerical error by Mennonite Mission Network or its agent in keeping records pertaining to plan coverage or delays in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment will be made when the error or delay is discovered.

In addition, any clerical error or delay by Mennonite Mission Network or its agent in enrolling an individual as required by the terms of the plan will not invalidate coverage for which an individual would otherwise be eligible.

L. Enforceability

The plan (as described in this summary plan description and related documents which together constitute the plan) is maintained for the exclusive benefit of Mennonite Voluntary Service participants of Mennonite Mission Network. As a participant in this plan, your rights to its coverage and any particular benefit that it provides are legally enforceable.

M. Privacy

The plan sponsor and the plan have adopted privacy policies in compliance with the Health Insurance Portability and Accountability Act of 1996 regulations on privacy and confidentiality of protected health information, outlined in 45 CFR §160 and §164, Subparts A and E, and security of electronic protected health information, outlined in 45 CFR §160 and §164, Subparts A, C, and D. The protected health information of a plan participant will be treated as confidential and will only be disclosed as allowed by the privacy policies, unless specifically authorized by the plan participant or as otherwise authorized by law, as outlined in the *Notice of Health Privacy Practices*.

Mennonite Mission Network will ensure that reasonable and appropriate security measures are created and implemented to the extent employees create, receive, maintain, or transmit electronic protected health information on behalf of the plan.

Restrictions on disclosure of your protected health information

You have the right to request restrictions on disclosure of your protected health information by notifying the plan in writing of your request for a restriction. Your request must be mailed to Everence and must describe in detail the restriction you are requesting. The plan is not required to agree to your restriction request but will accommodate reasonable requests when appropriate. You have the right to terminate an agreed-to restriction by sending a written termination notice to Everence.

N. Enforcing Law

This plan shall be construed and enforced by the laws of the United States and the State of Indiana.

O. Amendment of the Plan

The plan sponsor reserves the right to amend the plan and any or all benefits provided under the plan at any time without prior notice to plan participants. Any amendments to the plan will be in writing and made by resolution of the person or persons who have been duly authorized by the plan sponsor to take such action.

Properly executed amendments shall be delivered to the plan and the claims administrator (Everence). Plan participants will be notified of any amendment to the plan, in writing, by the plan administrator.

P. Termination of the Plan

The plan sponsor intends to maintain this plan indefinitely; however, it reserves the right to terminate the plan at any time, either in whole or in part, by an instrument properly executed and delivered to the plan and the claims administrator. Any such termination of the plan shall be made by resolution of the person or persons who have been duly authorized by the plan sponsor to take such action. Plan participants will be notified of any termination of the plan in writing, by the plan administrator.

In the event the plan is terminated altogether, plan liability for payment of claims shall be limited to payment of those claims incurred as of the date the plan is terminated. Neither the plan nor the plan sponsor shall have any liability for covered charges, fees, or expenses incurred after the effective date of the termination of the plan.

Part XVII, Miscellaneous Plan Information

Name of the Plan:
Mennonite Voluntary Service Health Plan

Type of Benefit Plan:
Group Health Plan

FEIN:
35-0893507

Plan Sponsor and Plan Administrator:
Mennonite Mission Network
Box 370
Elkhart, IN 46515
(574) 294-7523

Type of Plan Administrator:
Contract Administrator

Agent for Service of Legal Process:
Plan Administrator

Claims Administrator:
Everence Insurance Company
P.O. Box 483
Goshen, IN 46527
(574) 533-9511 or (800) 348-7468

Category of Eligible Individuals:
Mennonite Voluntary Service Participants

Plan Representative:
Betty Weaver

Plan Year:
Aug. 1 – July 31

Revised Plan Effective Date:
Aug. 1, 2020

Sources of funding:

Covered Participant	MMN Contributes	Volunteer Contributes
Mennonite Voluntary Service Participant	100%	0%
Spouse and dependents	100%	0%

Plan participants who are on extended coverage (see *Part XIII*) may contact the plan representative to determine the required premium for extended coverage.

Outpatient Prescription Drug Rider

This rider is attached to and becomes a part of the summary plan description for the Mennonite Voluntary Service Health Plan. It outlines the outpatient prescription drug coverage provided under the plan.

Your outpatient prescription drug coverage is administered through CVS Caremark. The plan only covers drugs available to the public with a prescription written by a physician, dentist, or practitioner licensed to do so, identified by a prescription number, and dispensed by a licensed pharmacist.

Coverage under this plan includes prescription drugs and medicines prescribed by a licensed physician in connection with the treatment of an illness or injury covered by the plan. This coverage includes insulin, insulin syringes, blood glucose and urine test strips, and lancets*.

*Insulin syringes, blood glucose and urine test strips, and lancets are also covered under the diabetes services provision in *Part IX, Section D,* of the base summary plan description.

Oral contraceptive drugs, contraceptive devices, and transdermal contraceptive patches available only by prescription are covered under the Adult Preventive Care Services provision outlined in *Part IX, Section N,* of the base summary plan description.

Coverage does not include:
1. Over-the-counter drugs;
2. Drugs that can be purchased without a prescription;
3. Drugs used to terminate a pregnancy;
4. Drugs that are considered experimental or investigative; and
5. Drugs not approved by the U.S. Food and Drug Administration for sale in the U.S.

Your outpatient prescription drug coverage is subject to the provisions and limitations outlined in the summary plan description. If you have questions about your outpatient prescription drug coverage, please contact Everence Member Services at (800) 348-7468 or (574) 533-9511.

Your membership card includes information about your prescription drug coverage which allows you to purchase prescription drugs at preferred prices. To take advantage of this arrangement, you must purchase prescription drugs with your membership card at a participating pharmacy. You can find the nearest participating pharmacy on the CVS Caremark website, www.caremark.com. **This plan will not pay for any prescription drugs when purchased without your membership card or at a non-participating pharmacy.** When you purchase prescription drugs using your membership card under this plan, benefits are not coordinated with other prescription drug coverage you may have.

You may also purchase prescription drugs by mail through the CVS Caremark Mail Service Program. To sign up for this service you must complete and mail an order form to CVS Caremark at the address on the order form for your first prescription. Refills can then be ordered by calling CVS Caremark at (800) 966-5772 or following the instructions on the CVS Caremark website, www.caremark.com.

When you use your membership card to purchase prescription drugs, you do not need to file a claim to receive benefits.

Compound Prescription Drugs

The plan will not cover compound prescription drugs that cost less than $300 and include an ingredient not approved by the U.S. Food and Drugs Administration.

In addition, compound prescription drugs costing $300 or more require preauthorization through CVS Caremark to ensure the medical necessity and appropriateness of the prescription.

You or your physician may call CVS Caremark at (800) 294-5979 to determine if a specific compound drug costs $300 or more and requires preauthorization prior to purchase at a participating pharmacy or through mail order. If a compound prescription drug requires preauthorization, your physician must obtain authorization through CVS Caremark at (800) 294-5979 prior to the dispensing of the drug. If the compound prescription drug is determined by CVS Caremark to be medically necessary and appropriate, the drug will be covered by the plan.

If you purchase a compound prescription drug that is not covered by the plan or if you do not obtain prior approval for a compound drug costing $300 or more through CVS Caremark, there are no plan benefits and you will be responsible for the total cost of the drug.

Prescription Drugs Costing $5,000 or More

All prescription drugs costing $5,000 or more require preauthorization through the claims administrator to ensure the medical necessity and appropriateness of the drug. This requirement does not apply to specialty pharmaceuticals which are required to be approved through CVS Caremark as outlined below and in *Part VIII, Section E,* of the summary plan description regardless of the cost.

You or your physician may call the claims administrator (Everence Insurance Company) at (800) 348-7468 to determine if a specific prescription drug costs $5,000 or more and requires preauthorization prior to purchase at a participating pharmacy or through mail order. If a prescription drug requires preauthorization, your physician must obtain authorization from the claims administrator (Everence Insurance Company) at (800) 348-7468 prior to the dispensing of the drug. If the prescription drug is determined by the claims administrator to be medically necessary and appropriate, the drug will be covered by the plan.

If you do not obtain prior approval for a prescription drug costing $5,000 or more through the claims administrator or if the drug is not covered by the plan, there are no plan benefits and you will be responsible for the total cost of the drug.

Cost Sharing

When you purchase prescription drugs with your membership card at a participating pharmacy, you are not responsible for any portion of the cost. The plan will pay 100% of the cost of all eligible drugs, as indicated in the following chart:

	Category of drug	Your copayment
Tier 1	Generic drugs	Plan pays 100%, you pay 0%
Tier 2	Preferred brand-name drugs on the Preferred Drug List	Plan pays 100%, you pay 0%
Tier 3	All other brand-name drugs	Plan pays 100%, you pay 0%
Tier 4	Specialty pharmaceuticals*	Plan pays 100%, you pay 0%

*Precertification required, as outlined in *Part VIII, Section E,* of the base summary plan description.

Generic and Brand-name Drugs

The generic name of a drug is its chemical name. The brand name is the trade name under which a drug may be advertised and sold. By law, generic and brand-name drugs must meet the same standards for safety, strength, and effectiveness.

Preferred Drug List

The Preferred Drug List is a specific list of prescription drugs selected by health care experts based on a drug's clinical and cost effectiveness. The list is provided to you after you are enrolled in this plan. Additional copies are available upon request. The Preferred Drug List is intended to be given to your physician so he or she can decide which category of prescription drug is best suited to your situation.

Specialty Pharmaceuticals

Specialty pharmaceuticals include oral, injectable, and infused medications that are biopharmaceuticals (bioengineered proteins), blood-derived products, and complex molecules. In general, specialty pharmaceuticals included in Tier 4 include, but are not limited to blood modifiers and drugs prescribed for the treatment of respiratory syncytial virus (RSV), growth hormone deficiency, Crohn's disease, hepatitis C, hemophilia, Gaucher's disease, cystic fibrosis, multiple sclerosis, rheumatoid arthritis, asthma, enzyme replacement, immune deficiencies, pulmonary arterial hypertension, and other chronic low prevalence diseases.

You may call Everence Member Services at (800) 348-7468 or (574) 533-9511 to determine if the specialty pharmaceuticals you or your covered dependent need are included in Tier 4.

You or your physician must obtain approval for all specialty pharmaceuticals through CVS Caremark at (800) 237-2767 before treatment initially begins and the drugs are purchased. You must purchase specialty pharmaceuticals from a Caremark specialty pharmacy, as directed by CVS Caremark in order for the drugs to be covered by the plan.

If you do not obtain prior approval for specialty pharmaceuticals through CVS Caremark or if you do not purchase the drugs as directed by CVS Caremark from a Caremark specialty pharmacy, there are no plan benefits and you will be responsible for the total cost of the drugs.

Maximum Quantity at Purchase

The maximum quantity of drugs you may purchase at one time when using your membership card is limited to:

1. A 34-day or 100-unit supply — whichever is greater — if you purchase prescription drugs other than specialty pharmaceuticals at a participating pharmacy;
2. A 90-day supply — if you purchase prescription drugs other than specialty pharmaceuticals through the CVS Caremark Mail Service Program; or
3. A 30-day supply – if you purchase specialty pharmaceuticals from a Caremark specialty pharmacy, as directed by CVS Caremark.

75 percent of the prescription must be used before refill is allowed for all prescription drugs other than specialty pharmaceuticals, 80 percent of the prescription for specialty pharmaceuticals.